The Strike at Harper Hospital

Survey of Auxiliary Nursing Personnel

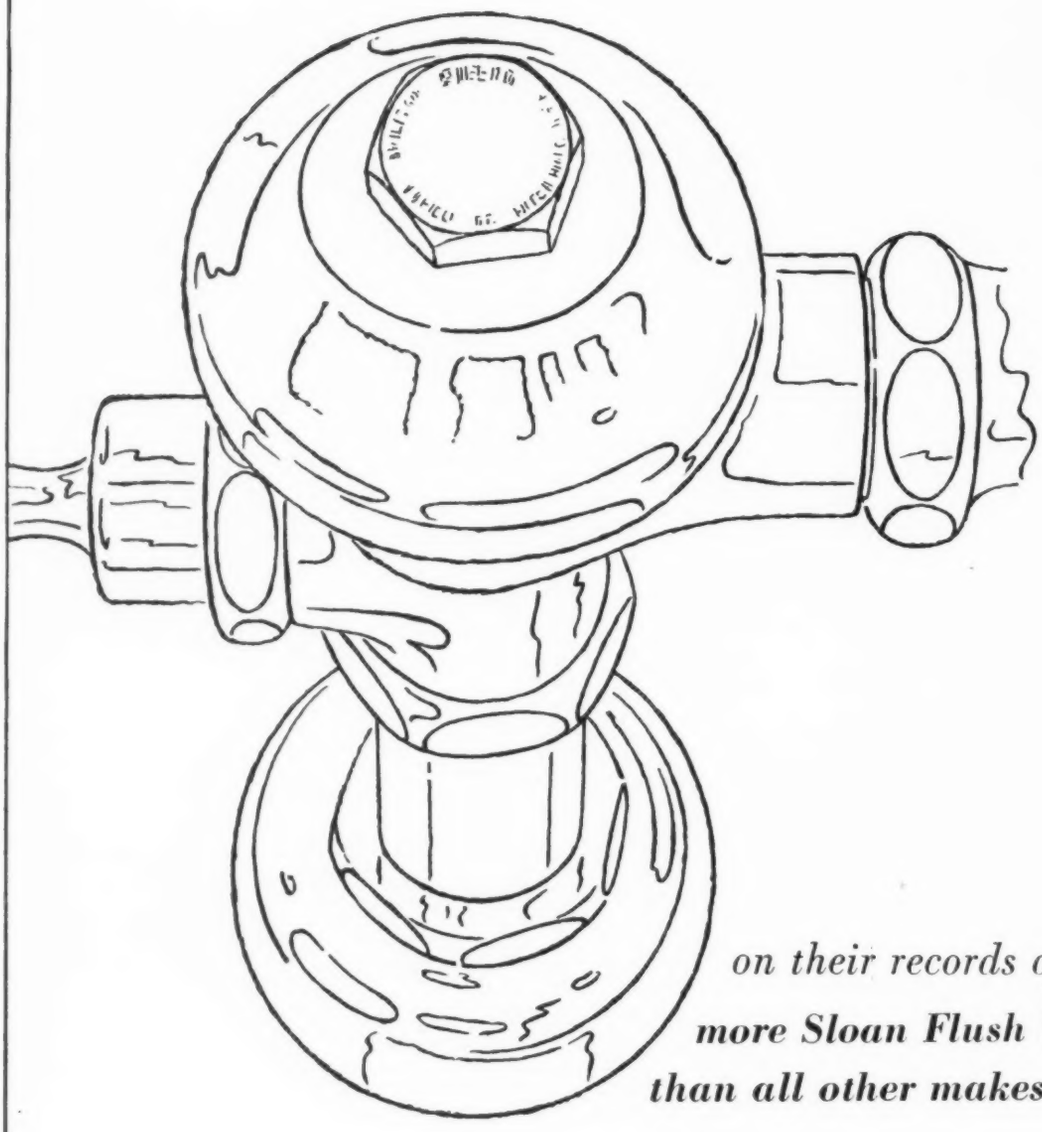
How Much Is an Administrator Worth?

December

VOLUME 71 NUMBER 6

1948

the Modern Hospital



on their records of performance,
more Sloan Flush Valves are sold
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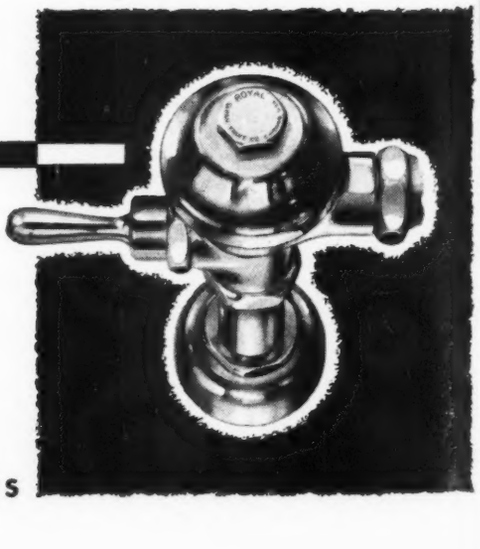

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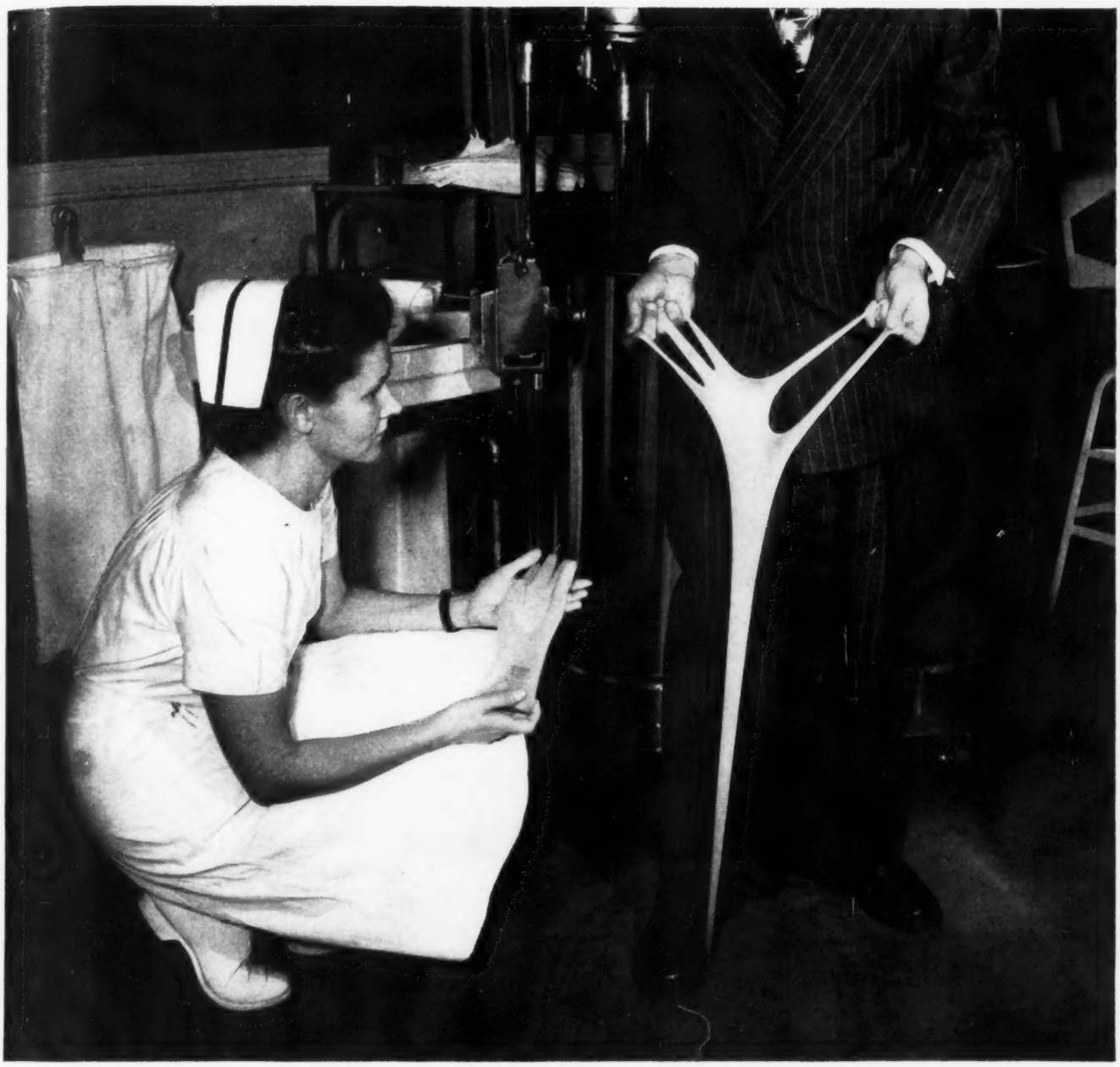

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In this issue:

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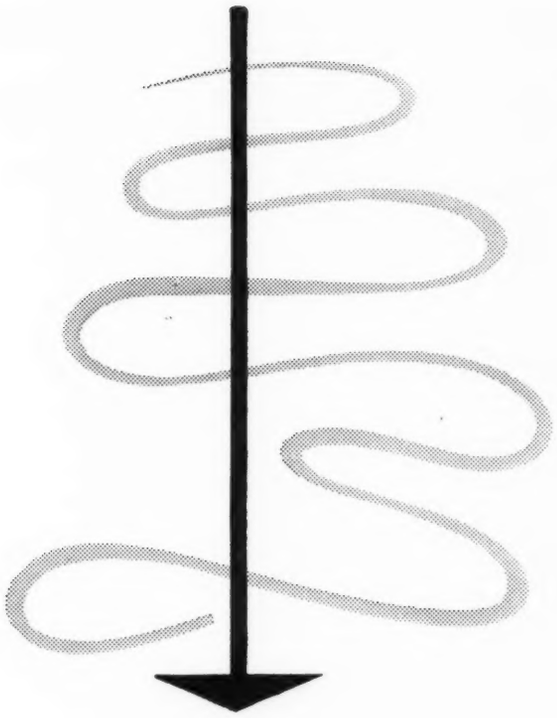

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AMONG THE AUTHORS

Dr. Karl S. Klicka is director of Woman's Hospital, New York City, a position he has held since his discharge from the army medical corps in 1945. A graduate of Western Reserve University Medical School and the University of Chicago course in hospital administration, Dr. Klicka became assistant director of Woman's Hospital, Detroit, in 1938 following completion of a rotating internship at Pittsburgh's Allegheny Hospital. In 1940 he went to Grasslands Hospital, Valhalla, N. Y., as assistant director, remaining there until he joined the army in 1942. His article appears on page 84.

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Roving Reporter

Schools Are Good Prospects

Hospitals eager to seek outlets for their newly acquired public relations technics will find many schools eager to get materials that will help teach children health and disease prevention.

G. B. Timmel of the department of health education, State Teachers College, Cortland, N.Y., recently told picked delegates at the first of several institutes for cancer control and prevention in the public schools to ask their local hospitals to give or lend x-ray films and microscopic slides showing cancerous tissue.

Schoolmen were urged to interest committees of pupils in arranging for an interview with the director of the hospital laboratory and to pay a visit to the place where diagnoses of cancer are made.

Prof. Timmel quotes the State Medical Society of Michigan's estimate that each year cancer kills several times as many children as polio, half as many children as tuberculosis, and two-thirds as many children as whooping cough.

Culture Two Ways

Jill isn't a dull girl at Grant Hospital, Chicago—not since August. Jill is frolicking; Jill is rollicking; Jill is extending herself in the direction of culture, both bona fide and beauty.

One evening a week Jill (and her fellow students) may study symphonies through music appreciation records and oral interpretation, this in preparation for her free night at the Chicago Symphony Orchestra concert. The hospital auxiliary provides the school of nursing with three season tickets, and these go to the students in rotation. Another evening the choral group meets, or a large cast rehearses the Christmas play.

But the evening that is most discussed is the one that brings the weekly lesson on the Body Beautiful, the emphasis being on poise. The school gets the course from a commercial studio, and the girls learn to walk with a textbook on their heads, to sit properly, and to make the most of their good physical points.

Mona Jackson, new director of the school of nursing and of nursing service, believes that the students through these various activities are in better form for assimilating their studies as well as for zestful and intelligent ward work.

Mrs. Dorothy Kitchens, formerly of Children's Hospital, San Francisco, is the counselor and social director of Grant's nurses. It is she who plans these cultural and recreational pursuits that supplement the usual monthly party for the students.

Identification Card

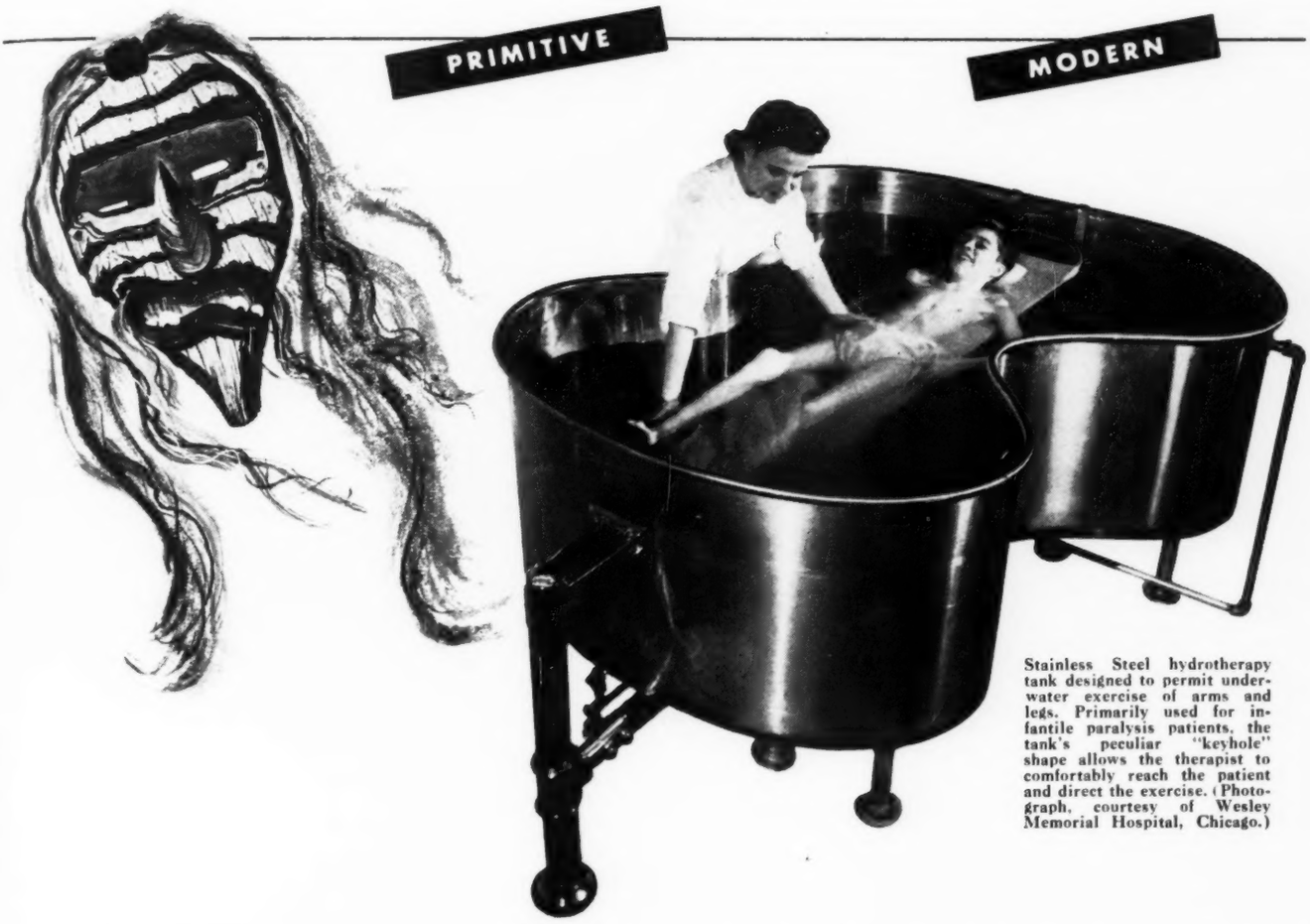
What may prove to be a neat way of keeping the hospital in the public mind is the identification card being sent discharged patients by St. Luke's Hospital, Kansas City, Mo. The idea is still in the experimental stage.

The card certifies that Joe Jones was Patient 7710, who entered St. Luke's on Sept. 30, 1948, and was discharged on Oct. 5, 1948. The card is prepared in the record room and is mailed to the patient within a week after his discharge. At this stage, Joe Jones's hospital experience is still of intense interest to him, and he is likely to stick the card in his billfold and think of the hospital whenever he sees it.

Someone has suggested to St. Luke's that it might be worth while to print a few outstanding facts about the hospital on the reverse side of the card. This, of course, would increase the printing expense.

The card is signed by the hospital's executive officer and carries the patient's home address. The serial number shows just how many patients were admitted before him during the year.

Psychosomatic Therapeutics



Stainless Steel hydrotherapy tank designed to permit underwater exercise of arms and legs. Primarily used for infantile paralysis patients, the tank's peculiar "keyhole" shape allows the therapist to comfortably reach the patient and direct the exercise. (Photograph, courtesy of Wesley Memorial Hospital, Chicago.)

THE primitive medico's therapy was more psychological than physiological. The healing ceremonies of the tribal witch doctor or medicine man were deliberately designed to treat the patient's mind as well as his body. We may laugh at his use of grotesque masks and paraphernalia but, by putting his patients in a favorable mind for recovery, he did bring relief and surprisingly often, actually cured them.

Today, the modern physician, whether deliberately or not, effects similar psychosomatic benefits through the use of Stainless Steel in hospital equipment.

For who can deny that patients respond favorably to the cheerful good looks and sparkling cleanliness of Stainless. Or that, when they see Stainless Steel all about them, they subconsciously feel they are better protected. And they are right. For Stainless Steel, in addition to its superior sanitary properties, cleans so easily and quickly that it relieves nursing staffs of much time-consuming labor. Thus, your patients benefit directly by the closer attention and better care that can be given them.

So plan to use Stainless Steel generously when you re-equip or modernize. And if you want the finest results from Stainless, equip with U·S·S Stainless! Here is a perfected, service-tested steel that for years has been used by leading makers of hospital equipment to assure the utmost in performance.

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UNITED STATES STEEL

READER OPINION

Convention Cocktails

Sirs:

Not often am I moved to comment when perhaps it is no affair of mine, but I should like to present my point of view on "Make Mine Moral," which appeared in The MODERN HOSPITAL last May.

In the last paragraph of "Make Mine Moral," it was suggested that "whoever seeks real release from tension should look in the Bible, not in the bottle." May I suggest the same idea for the writer of the article—particularly Romans: 14:10-13.

The same people who you claim set up these cocktail parties as a trap, shall we say, advertise in The MODERN HOSPITAL. I am wondering if their business was obtained in the same manner as you suggest they obtained part of theirs.

I like your magazine, but let's not make it a Sunday School paper.

Jane M. Boyd
Butler County Memorial Hospital
Butler, Pa.

See Proverbs: 12:1.—ED.

Appendix A

Sirs:

May I offer the following comments in reply to some of the statements made by Mr. Ellerby in the article "What's Wrong With Appendix A?" In so doing, I feel confident I can speak for a number of the states in our Western region that have had experience with the administration of P.L. 725.

"The red tape that is thus to be unraveled is quite beyond belief."

Seven sponsors of hospital and health center projects in Utah believe it possible to unravel the red tape involved. The sponsors of one have even been able to start construction and not later than June 21, 1949, will have a new hospital for their efforts.

"Worst of all, minimum standards are so excessive for the small hospital that relatively few communities that really need the grants will be able to avail themselves of the benefits."

Of our six hospital projects that are applying for federal assistance, one is an addition to a voluntary fifty bed hospital, and one is a fifty bed state hospital for poliomyelitis and other crippling children's diseases, which will provide statewide service, and for this reason was given a high priority. Of the remaining four projects, one is a ten bed hospital, one a fifteen bed hospital, one a thirty bed hospital, and the last a thirty-five bed hospital. All of these are in rural areas serving populations of relatively small financial resources, and all are in areas that desperately need hospitals.

The other high priority areas (areas of greatest need), advised of their opportunity to apply for financial assistance, in no case refrained from applying because of inability to meet minimum standards. Furthermore, no potential sponsors have withdrawn because of excessive costs involved caused by Appendix A or the unsurmountable red tape. We have experienced no withdrawals at all. In fact, if our annual allotment of federal funds were more than $365,100 per year, I am sure more projects would be under way. Proof of this is the

fact that additional applications from rural areas have actually been received or are known to be forthcoming in number sufficiently large entirely to obligate funds to become available as of July 1, 1949.

Utah may be added to Mr. Ellerby's list of states having adopted Appendix A *in toto* as the law of the state, doing so, I might add, only after requesting the advice and receiving the approval of our state chapter of the A.I.A., concerning the advisability of accepting such standards.

In our experience, Appendix A has been just the technical guidance Mr. Ellerby speaks of as being needed by hospital owners. From the present outlook in this state, at least the first four years' funds will be expended in building small rural hospitals; and our experience so far has strengthened our acceptance of Appendix A as a planning guide.

I further doubt that the U.S.P.H.S. or the state agency could administer the program more intelligently and effectively if Appendix A were nonexistent, certainly not as economically in states where the program is relatively small, such as ours. We have employed a local architectural firm, recommended by our state chapter of the A.I.A., on a fee-for-service basis to check plans for compliance with minimum standards. If the state agency had to be the sole judge, we would undoubtedly have to obtain a full-time architect and a hospital consultant of unquestioned authority, whom we cannot afford and quite likely couldn't obtain if we had the money to expend. Our program isn't large enough to occupy the full time of such individuals.

As a final point, I agree with Mr. Ellerby that a district headquarters of the U.S.P.H.S. with hundreds of plans to review cannot familiarize itself with each individual and local problem. In such cases the district may offer gratuitous (but certainly not irrelevant) advice that may not be the solution to the local problem. This has happened to us; but in such cases I feel that the architect for the project and this office are at fault because in every instance where we have found it necessary to deviate from minimum standards owing to an existing local condition, if the situation was fully explained in our written program and general notes were submitted with the drawings, a requirement of Appendix A, our recommendations have been accepted by the personnel of the 8th District of the U.S.P.H.S. Anyone who questions this need only review the drawings of some of our approved projects.

Robert A. Hunt
Hospital Survey and Construction
Utah State Department of Health
Salt Lake City, Utah

Rebuttal

Sirs:

It appears that the article "Sanatorium People Live Under Tensions," which was included in the October 1948 issue of The MODERN HOSPITAL, warrants a rebuttal. Physicians are perfectly cognizant of the emotional and psychological factors which are present in persons hospitalized in a tuberculosis sanatorium. Furthermore, a great deal of their time and effort is spent coping with such problems.

This article typifies perfectly the immature and biased attitude of the patient who has not been able to adjust himself psychologically to his disease and the restraints and sacrifices which its cure entails.

I am somewhat chagrined that a publication with the prestige and reputation of THE MODERN HOSPITAL failed to recognize and evaluate this article for what it represents.

Chester S. Koop, M.D
Rocky Knoll Sanatorium
Plymouth, Wis.

Opposing Views

Sirs:

The first editorial in the October issue of The MODERN HOSPITAL is quite interesting. It is extremely difficult to organize programs ahead of time so that there will be no criticism, but the suggestion embodied in this editorial strikes the heart of almost every national meeting.

Another suggestion in the editorial, which calls attention to the frequency of a unilateral approach to controversial subjects by national organizations, needs emphasizing. I should like to back you up in pointing out the value of presenting both sides of national problems whenever possible. This is what we attempted to do at our recent round table discussions during the second annual meeting of the College of American Pathologists. I am sure that all organizations could profit by a wholehearted attempt to have representation of opposing views during the discussion of such problems.

M. G. Westmoreland, M.D.
College of Clinical Pathologists
Chicago

SMALL HOSPITAL QUESTIONS

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Nurses' Salaries

Question: What is the average salary of the practical nurse as compared to that of the graduate? What is the average for the nurse's aide?—R.D.H., Ill.

ANSWER: Throughout the country, hospitals report that practical nurses (nine months to one year of training) are paid from 70 to 80 per cent of the scale for graduate nurses on general hospital duty. However, except in a few cities where hospitals have taken the initiative either independently or in cooperation with the public school system for establishing a training program for practical nurses, the supply of personnel with this training is eliminated.

Generally speaking, nurse's aides are paid from 55 to 70 per cent of the scale for graduate general duty nurses. In most cases, nurse's aides are hired without previous training and are given a few weeks of in-service or on-the-job instruction in the hospital.

Engineer's Qualifications

Question: What type of man is recommended for the position of chief engineer? Educational background? Age? Experience?—B.V.T., Wyo.

ANSWER: The type of man recommended for the position of chief engineer is one who is well qualified to operate all the equipment in the power plant, and who is able to learn how to operate all the equipment throughout the hospital. He must be honest, trustworthy and fair in his dealings with the men in his department, as well as with all other departments throughout the hospital. He should have an understanding of human nature, which is necessary both to handle the personnel problems that he will face and to keep the cooperation of all of the other departments in the hospital.

He should be a high school graduate and have had some mechanical training, as well as a desire to do this type of work. He should have at least five or seven years of experience in mechanical maintenance work, preferably in hotels or the maintenance department of an industrial plant. His age should be from 28 to 40 years so that he can spend at least 25 years with the hospital. His salary should be comparable to that paid in other industries in the community, otherwise it will be difficult to find a man well qualified and able to carry out the job that he is expected to do.—LEE MAMER.

Record of Stillbirths

Question: What record is it advisable for a hospital to keep on stillbirths? Our present policy is to complete the "stillbirth" record as required by the state department but no hospital admission record or number is made. Therefore, the only information concerning the child is incorporated in the mother's chart and noted in a book in the record room listing such births.

We feel that since the child was delivered here, it should be given a hospital number and record even though it is stillborn. We have discussed the problem here several times but seem unable to reach an understanding satisfactory to all concerned.—L.L.C., Ill.

ANSWER: We have recently adopted the policy of keeping the medical record of a stillborn separate from the mother's record. The record consists only of the identification record, the necropsy report, if a necropsy has been performed, and the cause of death supplied by the attending physician. The file number is assigned in the same manner in which numbers are assigned to other patients. An index card is placed in the index file for each stillborn child, as it is in the case of all admissions, and the record is cross-indexed in the doctor's file and in the standard nomenclature of disease.

In summary, a stillborn is handled in the same manner as any admission to the hospital; however, it is not added to the census as we do not consider it an admission in this sense.—ANNA M. BALL, R.R.L.

Employes' Progress

Question: How often, as a rule, should conferences be held with employes to discuss their work or general approach to it?—D.R., D.C.

ANSWER: The immediate supervisor of the employe should frequently discuss employe progress; at less frequent intervals, probably every six months, the department head or personnel officer should have a conference with the employe and evaluate his progress. General conferences should be held as often as may be required for discussion of policy changes.—WILLIAM J. DONNELLY.

Who Signs Pay Roll Checks?

Question: Is the practice general among administrators of hospitals of from 100 to 200 beds to sign pay roll checks personally?—J.L.B., Ill.

ANSWER: In many cases administrators of hospitals of 100 to 200 beds sign pay roll checks personally. Frequently, however, the assistant administrator, or some other full-time hospital employe, is also authorized to sign pay roll checks. This makes it possible to avoid delay in distributing them. WILLIAM J. DONNELLY.

Pay as You Go

Question: How general is the policy of payment in advance for nonemergency cases? How can this policy be enforced without offending patients?—R.C., Ill.

ANSWER: Unfortunately, the policy of requiring payment in advance is far too widespread in our hospitals. I would strongly urge that you do not adopt a policy of requiring payment in advance. We believe that more criticisms are directed to our hospitals as a result of requesting payment in advance than for any other single reason. Bills should be presented regularly while the patient is in the hospital. Every effort consistent with the hospital's avowed purpose of getting the patient well should be made to collect for services while the patient is still in the hospital or before discharge. However, sometimes this is not possible and in such instances the hospital should graciously make arrangements for payment after discharge. In our hospital we adhere to these suggestions and our bad debt loss is less than 2 per cent.—WILLIAM J. DONNELLY.

Looking Forward

Light for the Twilight Zone

SINCE the year 400 B.C. or thereabouts, when Hippocrates swore his famous oath by Apollo to impart his knowledge and art "to my own sons and those of my teachers, and to disciples, but to none other," doctors have resisted any intrusion into medical affairs by outsiders. Certainly this resistance has been a powerful force for good down through the centuries, and it remains today a bulwark of protection against quacks, cultists and unscientific or incompetent healers whose interest is not so much in the patient's pulse as in his purse.

There is evidence now, however, that some doctors may be carrying their resistance to outsiders into areas where its usefulness is questionable. Some of the objections to the national Blue Cross-Blue Shield proposals, for example, are thought to derive from fear of laymen on the board of directors of the projected association. The insistence of many radiologists and pathologists that there is something shameful about receiving a salary probably owes a little, at least, to the bogey of "lay control." So does the weird doctrine that "the medical profession has more to fear from hospitals than from the government"—a view that pops up occasionally in the medical journals.

Nobody in his right mind would quarrel with Aristotle's observation that "the opinion of the physician and that of the ignorant man are not equally weighty on the question whether a sick man will get well or not." Only a few medical zealots, however, can actually believe that everything having to do with hospitals and the economics of medicine also lies within the boundaries of the art which, by Apollo, will be imparted to sons and disciples and to none other. Unquestionably, the many functions that lie in the twilight zone between the practice of medicine and the business of medicine need sharper definition and better understanding. While the struggle toward these goals is going on, the zealots should be restrained, lest they do lasting damage to medical-hospital relations.

Doctors who use the word "layman" as an epithet should be urged by their calmer colleagues to contemplate Hippocrates, a man of great dignity and nobility to whom no other object was ever half so important as the welfare of his patients.

Avoidable Tragedies

IN RECENT months the newspapers have reported two operating room explosions that cost human lives. While the cause of these tragedies is rarely known outside the small circle of those who investigate and fix responsibility in an effort to prevent their recurrence, in most cases the final accounting indicates that the loss must be listed as avoidable. As one manufacturer has pointed out, "The anesthetic material usually gets the blame for an explosion, but nearly always it proves to be inadequately maintained equipment or the people operating the equipment that should be blamed instead. Even an explosive mixture cannot explode unless something ignites it."

The National Fire Protection Association states the same truth in different words in its pamphlet, "Combustible Anesthetics in Hospital Operating Rooms," which should be in every hospital administrator's office. "In preparing these safe practice recommendations," the association states, "it has been recognized that the behavior of materials and mechanical agents can be relied upon with greater assurance than can the behavior of human beings."

In most cases, ignition causing the operating room explosion is caused by defective electrical equipment or by static electricity. Many authorities believe that the association's recommendations concerning the installation of "explosionproof" operating room lights are needlessly severe and expensive, provided

other safe practice regulations are rigidly enforced. Hospitals observing the recommended practices governing recognition of hazards, ventilation, storage and handling of gases, electrical wiring and equipment, and reduction of electrostatic hazard will have little to fear from anesthetic explosions. Copies of the pamphlet can be obtained from the association at 60 Batterymarch Street, Boston 10. The price is 20 cents. The goal is safety for the patient—and peace of mind for the administrator.

Social Security

IN A hospital strike described elsewhere in this issue, pickets carried signs reading, "No Social Security for hospital workers!" Appearing alongside other signs protesting against alleged low wages and autocratic management of the hospital, the social security signs were manifestly unfair, with their plain implication that the lack of social security protection was the fault of this particular hospital. Actually, employes of the hospital in question have more security than most hospital workers do, because this hospital has provided a pension plan for which the employes pay nothing.

There is no good reason, however, why all hospital workers should not have the government social security benefits the strikers were obviously referring to. A bill to bring employes of nonprofit institutions, including hospitals, under the Social Security Act was introduced into the 80th Congress and was passed by the Senate. It got sidetracked in the House during the closing weeks of the session but is expected to come up for early consideration in the 81st Congress.

Most hospital people favor this legislation, which will add a little to pay roll costs but should pay off handsomely in greater job satisfaction and increased stability of the hospital working force, and in easier recruitment of workers, many of whom now shun hospital employment in favor of jobs that come under the act. The way to make sure the bill will get prompt and favorable consideration is to make sure your congressman knows how you feel about it, and why. If they're picketing hospitals with "No Social Security" signs a year from now, it will be largely the hospitals' own fault.

Worries and Words

AS THE end of another year looms, looking backward becomes the order of the day, even on a page labeled Looking Forward, and it occurred to us that the readers of these pages might be interested in a review of the subjects treated here during the year—a temperature chart, so to speak, of the hospital field as the editors saw it in 1948. So we have taken a backward look, and the vast range of our worries astonishes us.

Back there in January 1948, for example, we were concerned about the gap between hospital costs and payments for indigents, and the same subject engaged our attention several times again during the year. We were also brooding in January about the rarity of honesty among human beings—a circumstance that has occupied better minds over longer periods, to put it in the kindest possible way.

As the year went on, we fulminated about the divorce of public relations and truth, and about the fulminations of Old Doc Brady, the California seer. More in sorrow than anger, we remarked on the fact that Medicine was playing the big bassoons of Publicity. We became indignant when Blue Cross got pushed around. We worried hardest of all about radiologists and the alleged practice-of-medicine-by-hospitals—matters which we kept right on worrying about all year and expect to worry about some more. In our various angers and anxieties we called on St. Augustine, Ecclesiastes and the Psalm of David for support.

Later on, our temperature rose with the summer heat as we thought about racial discrimination in medical care and education. We tangled briefly with labor relations, lack of standardization in hospital supplies, purchasing practices, nursing and compulsory health insurance. Sitting up late, we wrestled with an interpretation of the philosophic significance of Frank Lloyd Wright's architecture—this being as close as we came all year to metaphysics. Returning to earth, we have worried since then about graft, convention entertainment, and hospital finances. In the last instance, at least, we have plenty of company.

In these recent struggles we have sought help from the Proverbs, Shakespeare and, again, St. Augustine, who surely came as close to understanding the truth as any man who ever lived. In our own small efforts to reveal fragments of truth, it must be admitted, we have pounded more heads than we have patted. This is a practice St. Augustine would disapprove and we would be inclined to regret if it weren't for our conviction that head-patting journalism is a waste of time.

As the year ends, we are grateful alike to those who have expressed appreciation of our words and those who have shown us the error of our ways. We look forward now to another year of Looking Forward, confident that though we may strive mightily and accomplish little, still we have accomplished something in the striving. Like Jeremiah, we shall reproach the unbelievers who say that the pen of the scribes is in vain.

Detroit Times Photographs

STRIKE!

The Issue at Harper: Do Unions Belong in Hospitals?

THE bedrock issue between organized labor and voluntary hospitals was at stake last month when Detroit's big Harper Hospital flatly refused to recognize or deal with a powerful union claiming to represent the majority of Harper's nonprofessional employes. In a struggle of far-reaching significance to hospitals throughout the nation, Harper stood squarely against unionization of hospital employes through six months of meetings, pronouncements, threats, hearings and court actions, then fought back fiercely with emergency measures when the union did its worst and pulled 450 hospital workers out on strike.

Massing noisy pickets at the hospital entrances, slugging, kicking and even pulling knives on workers who tried to cross picket lines, the strikers crippled hospital service for three days while doctors, nurses, trustees and other volunteers ran the elevators and the laundry, swept floors, pushed food carts and hauled out garbage. Then, encouraged by police protection, an injunction against violence and an overwhelming upsurge of public opinion opposing a hospital strike, workers began to return to their jobs. At the end of a week less than half the strikers remained out and the hospital was functioning normally in most departments. Picket lines still paraded on hospital sidewalks (typical sign: "No social security for Harper Hospital workers!"), but tension had eased. From the hospital's standpoint, the battle was in its mop-up phases.

The principle that the hospital defended throughout the preliminary union maneuvers and the strike is one that many hospital administrators and trustees believe in but few have declared in these years of labor's ascendancy. In its

Union officials (back to camera) discuss strike issues with members of a governor's panel attempting to effect a settlement. Recognition of the A. F. of L. union was the principal issue.

simplest terms, the principle was stated by Dr. E. Dwight Barnett, director of Harper Hospital. "A hospital isn't a factory," he said.

Explaining his point of view, which is fully supported by Harper trustees, Dr. Barnett pointed out that the hospital exists to serve the patient, and that management charged with responsibility for the patient's welfare must necessarily maintain full authority over all hospital personnel. Recognizing a union as bargaining agent for any group of employes, he insisted, would mean relinquishment of some of the authority that should remain with the hospital.

"In one city-owned hospital whose employes are unionized," Dr. Barnett related by way of example, "a union orderly refused to carry out a treatment routine requested by the nurse in charge. She fired him immediately, because the chain of command in a hospital, as in an army, must be respected.

THEN THE UNION STEPPED IN

"In this case, the union stepped in, demanding reinstatement of the orderly and further requesting that orderlies be removed from the jurisdiction of nurses—in violation of recognized and proper hospital practice. When a union is bargaining agent for a group of employes, such demands, even though they may jeopardize patient care, have to be listened to."

The principle that Dr. Barnett defends was stated publicly the day the strike started. Speaking for the hospital, Oscar Webber, a member of the board of trustees, told newspaper reporters why the hospital would not deal with unions. "We believe that it is not in the public interest to unionize hospitals," he said. "Unionization would seriously affect the care and welfare of the patients we are organized to serve. . . . It is our belief that the vast majority of the people of Detroit will support our position."

In a resolution adopted by unanimous standing vote during a special strike-week meeting, the hospital's medical staff made its position equally clear. "Our sole concern in this matter is the type of care the patient receives," the staff statement said. "When a person is sick and requires hospital care, our responsibility is to render that individual the best possible care and medical attention. In rendering such service there can be no division of responsibility or authority if the best interests of the patient are to be served. The board of trustees has delegated such responsibility and authority to the hospital director, Dr. E. Dwight Barnett, and we, the members of the medical staff, approve this action."

Another point was added by Dr. Barnett, who sees the essential difference between hospitals and industry as a basic factor in the labor outlook for hospitals. "The cost of a labor dispute or strike in a factory can be taken up by increasing prices," he explained to a reporter. "The customers can decide whether to pay or not. Nobody has to have that particular product.

"This is not true of a hospital. The patient does not have a choice of whether he wants to go or not. That is why the hospital has a greater responsibility. It must be there, and it must be ready to perform its duties. We cannot have any interference, because sometimes clockwork precision of care is the difference between life and death."

As it affects labor, the hospital's position is "autocratic, ancient and obsolete," according to Floyd Loew, organizer and strike leader of the Hospital Employees Union, an American Federation of Labor affiliate. "The hospital has shirked its responsibility to the community by refusing to bargain with employes," Loew said in a pre-strike pronouncement. Describing Trustee Webber as "the czar of Harper Hospital," an editorial in the *Detroit Labor News*, A. F. of L. paper, said that "organized labor deplores the necessity for striking a hospital." However, the paper continued, "when an individual of such an autocratic type is in charge, the workers have no other avenue in which to carry their fight for justice."

The principle at stake in a labor dispute can usually be expressed by one side or the other in terms of cash. In the Detroit strike, union communiqués referred repeatedly to the "meager wages and deplorable working conditions" that prevailed at the hospital. "Look at your hospital bill," Loew said in one public statement issued during the cold war that preceded the walkout, "and ask yourself if there is any reason why hospital employes should not be paid a living wage." Hospital wages, the union stated flatly in another of its bulletins, "are substandard and far below those paid in the lowest-paid comparable industry."

CITE CURRENT WAGE RATES

In reply to this charge, hospital officials cite wage rates now in effect at Harper and invite comparisons. Under an existing contract between a number of commercial establishments in Detroit and the Hotel and Restaurant Employees International Union, A. F. of L., for example, vegetable cooks get $30 for a six-day week. At Harper, vegetable cooks start at $37 and get automatic increases up to $41.50 after two years, working only five days. Second cooks under the A. F. of L. contract get $55. At Harper, the scale for second cooks is $57.50 to $62. A. F. of L. porters get $27 a week for hotel and restaurant work; Harper porters start at $32.50, earn $36.50 after two years.

Similar comparisons can be made in every department but will fail to show where wages are "meager" or "substandard," the hospital maintains. In the hospital laundry, where union organizers had signed up 100 per cent of the workers by the time the strike was called, ironers were getting 57½ cents an hour, washers, $1.06, and loaders, 89 cents. A nearby commercial laundry

paid the same classes of workers these rates under an A. F. of L. union contract: ironers and press operators, 55 to 65 cents a hour; washers, 95 cents to $1.22, and loaders, from 85 to 93 cents.

At rates that vary from $33.50 to $41.50 a week, typists, office clerks and stenographers at Harper Hospital are paid a little more than are similar workers in a Detroit department store and a little less than their counterparts in a public utility office. Clerks in a large hotel get the same wage as hospital clerks.

"Conditions of employment for Harper Hospital employes definitely are below those of employes doing similar work in other industries," the union told members and prospective members and anybody else who would read its mimeographed announcements.

"Judge for yourself," a hospital personnel officer told the reporter, handing him a copy of the hospital's personnel handbook. Excerpts:

"All full-time employes will work on an eight-hour day, forty-hour week basis. Because of the nature of hospital work, it is necessary that certain employes work on Saturdays and Sundays. The hospital attempts to keep at a minimum the number of employes who are on duty these days.

"Whenever the department head or supervisor requests an employe to work over his scheduled eight hours, the employe is given his choice . . . of extra pay or additional time off to compensate for the overtime.

"For each job [there is] a minimum starting wage and periodic raise schedule. These periodic raises are given for length of service.

"There are six paid holidays each year. . . . Holidays will be given on the days when they occur whenever possible. When it is not possible, another day will be given instead of the holiday.

"Harper Hospital has provided for a noncontributory pension plan for its long-term employes over 65 years of age. This plan provides benefits similar to those of commercial plans in which employes contribute; however, our employes make no financial contribution."

Looking at these and other provisions of Harper's personnel program, one wonders why the union chose such a tough nut to crack first. The answer may lie in the hospital's location. Harper is on the rim of Detroit's Black Belt. One entrance to the hospital is in a predominantly Negro neighborhood; a block away, the other door opens on a street that is all white. "During the wartime race riots here," a hospital executive said, "we were taking injured Negroes in one door and injured whites in the other."

In these borderline areas racial tension is always present, a reservoir of fury and suspicion that can be drawn on by anyone whose ends it will serve. During the cold war at Harper, it served union ends to let it be rumored that the hospital was going to fire colored workers and replace them with whites. Ninety per cent of employes in the laundry, housekeeping and dietary departments were colored. When the strike came, ninety per cent of those who walked out were colored.

"We knew last April that union organizers were beginning to talk to our employes," Dr. Barnett related. "Soon afterwards, we got a copy of a letter from the union to the state labor commission outlining union plans. Then Loew came into my office and told me that he represented the majority of our nonprofessional workers and wanted a contract."

When Dr. Barnett stated the hospital's no-bargaining policy, the union registered a labor-management dispute with the state and requested a hearing before the State Labor Mediation Board.

"If there was any doubt before about what the union wanted, it became perfectly clear at the hearing," Dr. Barnett continued. "In the first place, they demanded recognition as representatives of all employes except doctors, nurses and those in supervisory and confidential positions. Union representatives later denied that they wanted a closed shop or hiring-hall privileges, but this is what they said." Dr. Barnett read a union statement from a transcript of the hearing: "'We want to service the hospital. We supply help for all the institutions we deal with. We can't maintain that service unless we have what you want to call union shop conditions. We would insist they use it.'"

The hospital's position throughout was that no dispute existed because the hospital was not recognizing or dealing with the union in any way. An attorney representing the hospital attended the hearing as a courtesy to the board but did not state or argue the hospital's case, which he claimed was not mediatable.

At about this time Dr. Barnett wrote a letter explaining the situation to other hospital administrators in the area. "The union feels that if it can make an issue over recognition alone, the mediation board would probably recognize the right of the employes to create a bargaining unit of their own choosing," he reasoned, "thus ordering the hospital to bargain with the unions involved."

But it didn't happen that way. Instead, the course of events was turned in another direction by a point of law. The Bonine-Tripp Act, a Michigan labor law, calls for compulsory arbitration of a labor-management dispute arising in "any public utility, any municipally owned utility, or any hospital," when appeal to the mediation board fails. In a prior dispute involving a bus company in Flint, the constitutionality of the law had been challenged on the ground that one member of the compulsory aribitration board

Left: Dr. E. Dwight Barnett, director of Harper Hospital. Right: Floyd Loew, A. F. of L. organizer in charge of the strike.

was a circuit court judge, a public official who was thus improperly serving in both the judicial and executive branches of the government at the same time.

In September, the compulsory arbitration law was ruled unconstitutional by the state supreme court, and the union was on its own. On October 15, Loew announced his intentions: "This is to serve notice on the relatives of patients at Harper Hospital to take the necessary steps to protect the sick by moving them to other institutions."

Five days later, union members were alerted: "You stand instructed to be ready to strike on a minute's notice should any hostile action be taken by the hospital," this war-like bulletin declared. "Do not be afraid of threats. Do not fall for phony promises. Do not let them, in any way, break down your solidarity."

When it finally came the morning of November 8, the strike hit chiefly at four hospital departments. Worst off was the laundry, where more than 40 workers — the entire department — stayed out. Also paralyzed momentarily by the strike were the housekeeping and dietary departments, each with approximately 100 workers missing. Off the job, too, were most of the hospital's ward helpers—the only striking group that was not predominantly Negro. When the final count was made for the first day of the strike, 446 employes—one-third of the hospital's total working force—were missing.

AFRAID TO CROSS LINES

"We have no way of knowing how many of the strikers were union members and how many stayed out because they were afraid to cross the picket line," Dr. Barnett said. "The union's campaign of intimidation must have kept many workers away who wanted to work; a few of them called up their supervisors and said so. The picket line formed at 5 o'clock Monday morning. As union workers came to the hospital they joined the line instead of reporting for work."

Violence on the picket line started late on the first day of the strike and continued for three days. An intern crossing the line got into an argument with a union organizer (see page 43) and was slugged. Pickets attacked and beat a hospital dietitian as she left the hospital. Another woman worker was knocked down and kicked. A woman who had been visiting a hospital patient was threatened with a knife. Several arrests were made. Three pickets were held for trial on assault charges; others were dismissed for lack of material witnesses. After three or four days of scuffling, the circuit court enjoined pickets from illegal activities, mentioning specifically personal violence, intimidation, barring entrance to and exit from the hospital, congregating and loitering. To prevent another strike nuisance, police threatened to invoke a little-used city law prohibiting noise in the vicinity of a hospital.

During the strike, a surgical resident was initiated into the mysteries of operating a mangle.

As picket lines dwindled and calmed down under these restraints, the emergency organization that kept the hospital going was functioning more and more smoothly. When the strike started, the crippled services were immediately staffed with volunteers, nonemergency admissions were canceled and recruiting and hiring of workers were stepped up. "We didn't lower our standards, but we sure speeded up the pace," James Gersonde, administrative intern assigned to personnel, explained.

"We ran an ad in the papers the first day," Gersonde continued, "and the next day we had 250 job applicants. We hired twenty-eight, or about 10 per cent of the applicants—our usual ratio. The next day we had 142 applicants and hired twelve. Then we changed the ads to get a better selection of applicants, and the pace slowed down a little. By the end of the week, we had hired about sixty new employes."

Strikers were given a week to decide whether or not they wanted their jobs back. In a registered letter sent to each striker's home address November 10, Dr. Barnett stated, "Because you have remained away from work on account of a strike you are hereby notified that you are dismissed. . . . You will be given a final opportunity to be rehired if you appear ready to work on or before Monday, November 15. If you do not appear by that time you will not be rehired. If you do return by that time your length of service will not be affected. . . . If you are not one of the strikers but are staying away from work because of fear . . . please phone your supervisor at once. The police have promised to give protection to you if you do wish to return."

When the Monday deadline came, all but 200 of the strikers had returned, hospital officials reported, and plenty of applicants were on hand to take their places.

Many workers who stayed on the job or returned early in the week but were afraid to cross picket lines were given emergency housing at the hospital. Patient areas that had been closed for lack of nurses were used as temporary living quarters for these employes. A nursing arts demonstration ward housed some. A research unit with a few beds offered additional space. Altogether, living room was found for 120 workers; the personnel department quickly made things as home-like as possible and improvised a recreation program. "We had a movie here Wednesday night," Gersonde said, showing a visitor one of the nursing school classrooms. "Pretty good one, too," he added thoughtfully.

VOLUNTEERS PITCHED IN

It was the volunteer workers, however, who made it possible for the hospital to survive the first seventy-two hours of the strike: A urologist ran one of the elevators six hours an evening. A surgical resident operated a mangle in the laundry. A hospital trustee stood his turn behind the salads in the cafeteria line. Doctors' and trustees' wives staffed the kitchen and housekeeping departments. Administrative assistants worked around the clock, helping out wherever they were needed.

Gersonde, for example, excused himself from a visitor he had been showing around the hospital. "I've got to get on that garbage detail," he explained. Assistant Administrator

George Cartmill, whose wife was dishing up mashed potatoes in the cafeteria, also did an after-hours turn on the garbage disposal line—a major operation because the hospital had switched to paper cups and plates when the dishwashers failed to show up.

The volunteer response outside the hospital was as strong as it was in these interested groups. "A department store executive stops here on his way home in the evening and sweeps the first floor corridors," said Roy Stephenson, coordinator of volunteer workers. "Five hundred members of Rotary have offered their services in any way we want to use them. A woman whose husband belongs to another union offered to organize a group of union wives to help the hospital. A 7 year old boy wrote to ask if he could come in and wash the dishes for us."

LETTERS TO THE EDITOR

The letters columns of Detroit newspapers reflected public reaction to the strike. One day's paper printed several such letters. "It floors us . . . I have a few hours I could contribute each evening," one reader said. "Innocent people could be dying," another pointed out. Another letter expressed indignation at the jeopardy to proper health care. Still another reader had a plan to organize high school volunteers.

In a front page editorial entitled "Striking Against the Sick," the *Detroit Times* stated what was obviously the feeling of most of the community: "We are not equipped at this time to judge the legal aspects of the strike and the relative merits of the policies in conflict," the editorial said. "We do believe emphatically that it is wrong to strike against sick patients in hospitals who are not parties to any labor dispute except that they happen, unfortunately, to be in the middle."

As Dr. Barnett understands it, this overwhelming public sentiment against hospital strikes does not relieve the hospital of any responsibility to its workers. On the contrary, it increases that responsibility. "Because of our policy we must show extra fairness to employes," he explained, "but we do not feel that a hospital should be required to pay a great deal more than is paid for the same work by a company organized for profit."

Whatever the final result at Harper, Dr. Barnett believes the most important fact about the strike is that it has drawn the sharp line that had to be drawn between hospitals and industry. "Hospitals are going to have to analyze their labor needs," he said. "We have a need that is different from industry's. We must see how acceptance of unions in the hospital field can be accomplished without interfering with patient safety or care. Until we can accomplish this, we must fight."

For Faster Admissions

MORE and more hospitals are using pre-admission registration forms to save time and trouble for all concerned at the time of admission. Forms in use vary from an elaborate preliminary history running to several pages, in one hospital, to compact blanks such as the one shown here, which was adopted recently by the Presbyterian Hospital of Chicago and is furnished to doctors on the hospital staff, who distribute it to patients in their offices at the time hospitalization is decided upon.

"I have had a number of good reports on it," Leslie Reid, administrator, says of the form, "and we find that this practice greatly relieves the waiting period in our admitting office and also provides the patient's family with information relative to visiting hours. We are very happy with the form and look forward to its continued use."

THE PRESBYTERIAN HOSPITAL
1753 W. Congress Street
Chicago 12, Illinois
Telephone: SEEley 7171

Your completion of the following Form in advance of your arrival will facilitate your admission to the hospital. This information will become an essential part of your hospital medical record. On arrival at the hospital, hand the completed form to the Room Clerk who will assign you to the accommodation reserved for you. (Please write plainly)

Patient _____
First Name Middle Name Last Name

Address _____
Telephone _____

Physician _____

Age _____ Sex _____ Race or color _____

Here Before? _____

Date of Birth _____
Month Day Year

Place of Birth _____

How long in U. S. if of Foreign Birth _____

How long in Chicago _____

Single Married Widowed Divorced Separated

Husband or Wife of _____

Relative or Friend _____

Address _____

Telephone _____ Relationship _____

Patient's Occupation _____

Employer _____

Address _____
Phone _____

Bills Paid by _____

Address _____
Phone _____

Signature of Person Responsible for Hospital bill _____

Do you have Hospital Insurance? _____

If Blue Cross, give name of Plan _____

Location _____ Certificate No. _____

Name of Subscriber Group with which Member is Enrolled _____

Patients with insurance other than Blue Cross may bring the necessary forms to the Special Service Department for assistance in their preparation.

Religious Denomination _____

If you desire that we notify your pastor of your admission to the Hospital, please state his:

Name _____

Address _____

INFORMATION FOR YOU
as an incoming patient of
PRESBYTERIAN HOSPITAL
1753 W. Congress Street
Chicago 12, Illinois
Telephone: SEEley 7171

When you become a patient in Presbyterian Hospital all of our facilities and efforts are directed toward providing you with the skilled, efficient, and sympathetic service that will minister to your comfort and hasten your recovery.

During the course of your hospital stay it may be necessary for you to leave your room to receive examination or treatment in one or more special departments. We suggest, therefore, that you leave personal valuables at home. Such funds as you plan to use while in the hospital should be deposited with the cashier at the time of admission. A safekeeping receipt will be given you and withdrawals may be made in accordance with your wishes.

• • •

VISITING HOURS are established for the welfare of our patients. You will want to inform your friends about the visiting regulations, as follows:

MEDICAL AND SURGICAL FLOORS

Private Rooms—9:00 A. M. to 9:00 P. M.
(If condition of patient warrants)
Semi-private and other Wards: 2:00 — 3:00 P. M. Weekdays
2:00 — 4:00 P. M. Sundays and holidays
7:00 — 8:00 P. M. Tuesday, Thursday and Saturday

Only two visitors allowed at one time.
Children under 14 years not permitted to visit in wards.

CHILDREN'S DEPARTMENT

Private Rooms—Daily, if patient's condition warrants.
Wards—2:00 to 3:00 P. M. Wednesday and Sunday
Not more than two visitors per day.
Children under 14 may not visit in wards.

MATERNITY DEPARTMENT

Private Rooms — 9:00 A. M. to 9:00 P. M.
(Except when babies are in mothers' rooms)
Semi-Private and other Wards: 2:00 — 3:00 P. M. Weekdays
2:00 — 4:00 P. M. Sundays and holidays
7:00 — 8:00 P. M. Tuesday, Thursday and Saturday

Visitors limited to husband and one other person per day.
The husband may visit both afternoon and evening on Tuesday, Thursday and Saturday.
Persons under 16 years not permitted to visit in the Maternity Department.

The above restrictions are in accordance with Board of Health Regulations to safeguard mothers and babies.

• • •

WHEN YOU LEAVE THE HOSPITAL

On the day of your discharge from the hospital, we ask your cooperation in arranging to leave on or before 2:00 P. M. so that your room or the ward bed you occupied can be made ready as soon as possible for another patient who is awaiting admission.

EXTERIOR VIEW OF ST. FRANCIS HOSPITAL, LYNWOOD, CALIF.

The Architect Had a Problem:

Building on a Limited Budget of both money and materials

GEORGE J. ADAMS
Architect, Los Angeles

INTERIOR OF THE ENTRANCE LOBBY

ST. FRANCIS HOSPITAL, located in the city of Lynwood, a suburb of Los Angeles, is the only general hospital with a capacity of more than 100 beds that has been constructed in Southern California since the outbreak of World War II. Its construction and planning are unique, inasmuch as the building was erected as a part of the federal emergency building program under the supervision of the Federal Works Agency. The conservation of critical materials necessitated plans that would eliminate all waste and reduce the use of metals, such as piping, conduit and copper, to the very minimum. As a result, an examination of the drawings shows a concentration of mechanical equipment and the location of similar equipment through the floors, so that the length of service pipes is at a minimum. For the same reason, the rooms in need of air conditioning are all gathered together in one compact mass, with the air conditioning equipment removed from the general boiler room and placed directly against the areas being served.

The building is situated in the southwest suburban area of Los Angeles made up of industrial and manufacturing districts with contributing residential areas for the medium income groups. The need for hospital facilities in this section had been pressing for a number of years, so that in 1943, an application was made with the Federal Works Administration for federal aid in the construction of a general hospital. The request was made by

the Sisters of Saint Francis, a religious community of the Catholic faith experienced in the administration of hospitals. The approval of the application stipulated that the building must conform to the restricted use of materials and that it should be all fireproof construction with the use of wood reduced to a minimum.

In the preparation of the plans, Robert Stanton assisted the architect as hospital consultant, and in the fall of 1944, contracts were let for the construction of the building with a capacity of approximately 150 beds and including the normal facilities of a general hospital. The following year, the hospital was opened and it immediately took its proper position in the service for which it was intended. Since that time, the building has been continuously filled to capacity or near capacity.

The general layout shows the location of the building at the intersection of two important boulevards with a setback from each deep enough to ensure quiet. The main structure is four and five stories high with a one-story service and storage wing. The need for a service wing above ground and at the same level with the first floor was clearly indicated at the start of planning owing to the height of ground water below the surface of the ground and the possibility of surface water's entering a basement during abnormal storm conditions. In addition, the analysis of the soil indicated that it could not furnish normal support for a heavy building, and the fact that the structure is located in an area containing earthquake faults made the study of the foundations extremely important. As a result, all of the building but the service wing is constructed on concrete piles from 25 to 40 feet deep and all basements were eliminated. There is, however, crawling space under the entire area for the servicing of mechanical lines below the first floor.

An examination of the plan of the service wing reveals the abundance of light and air that has been provided for the service rooms through this arrangement and it is questionable if justification for placing these rooms in a basement could be established except where the cost of land is extremely high. Such rooms as the laundry, the kitchen and boiler room all have natural cross ventilation; they are flooded with light, and are pleasant

(*Continued on Page* 50.)

The Consultant Comments:

This Plan Warrants Study

ROBERT STANTON

Architect and Consultant
Carmel, Calif.

BECAUSE I am an architect who specializes in hospital design, I know the difficulties Mr. Adams encountered in designing the first fireproof postwar hospital in California. The limitations imposed upon him were enormous, including an extremely limited budget, voluminous war production directives and many others. In spite of all these he produced a fine workable hospital which contains many features that warrant study.

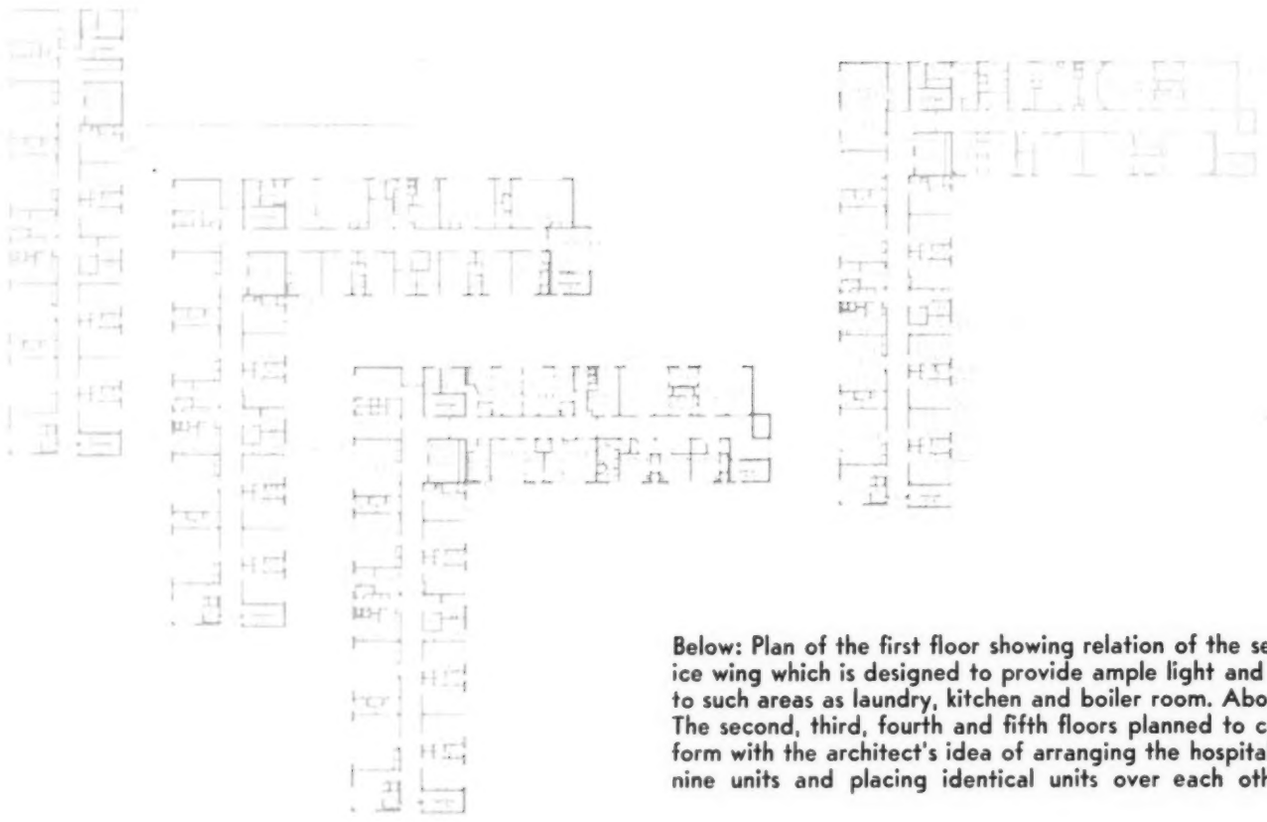
May I suggest that you examine the nursing station unit and its adjacent areas. Note the nurses' lockers in the hall leading from the station to the airing balcony; also, the toilet facilities for the nurses. This toilet is on the outside wall and requires no mechanical ventilation. This area is extremely compact. Mr. Adams has crowded almost every facility that a nurse needs into this small area and has left out none of the essentials. This area works, and works well. Note the airing balcony which is so often needed in a nurses' station but is so infrequently provided.

The location of the incinerator and the dirty linen chute which goes to the first floor should be given consideration, as should the water sterilizers in the utility room. Most hospital plans show such equipment in the operating suite's substerilizing room or central supply. Hence, someone has to bring this water to the nurses' station when it is needed, causing wasted steps of personnel. Note the drinking fountain in this area. A unique feature is the medicine room with its outside light. Here a nurse may enter, close the door and prepare her medicines without distraction from conversations at the nurses' station.

There is another bit of ingenious planning in the bathroom areas between the four-bed wards and two-bed rooms which allows the use of the bathtub by one patient and simultaneously the use of the toilet by another while a third may be using the handwashing facilities. These facilities may be used while the nurse is using the handwashing facilities. None of these areas requires mechanical ventilation because there is a low wall between the toilet room, the bath area and the exterior wall.

The central sterlizing supply room is located in the center of the house horizontally as well as vertically. Some day a wing will be added to the west of this room. The location of added beds at some other time was well thought out in the original planning and can be done with the least amount of discomfort to patients and at a low cost per bed. Another item that I believe is important is the size and location of the doctors' examining room between nurseries. This is a tiny room but it serves the purpose, and serves it well. It definitely keeps the doctors out of the nurseries.

As was stated in the beginning, Mr. Adams was working with a limited budget and was obliged to make every dollar go to its very limit. This he did admirably.

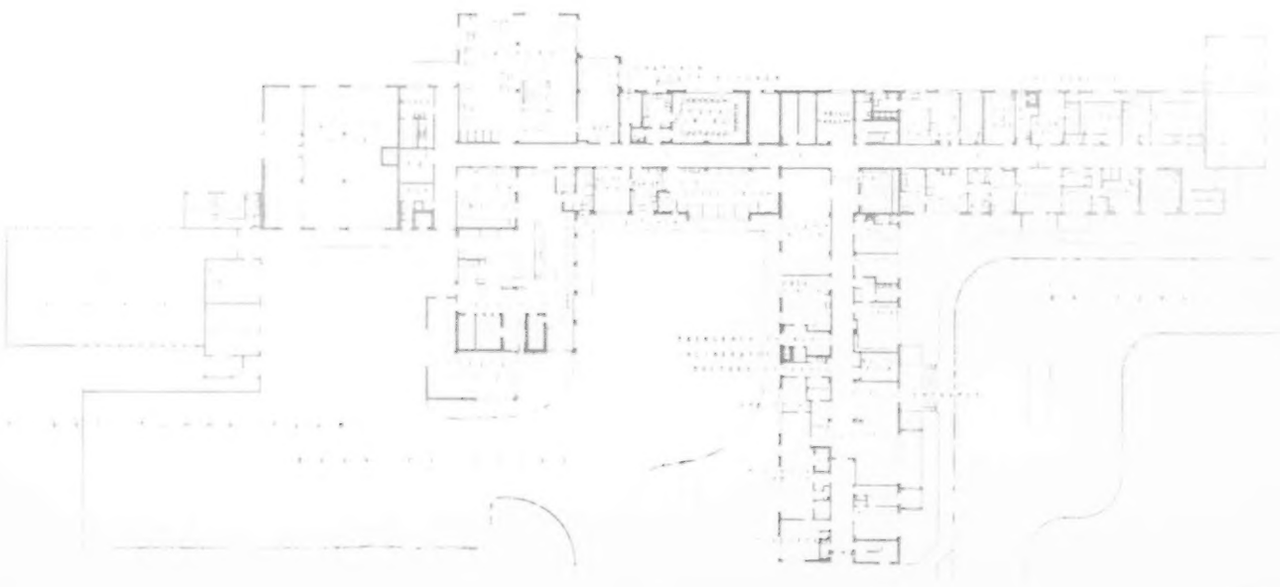


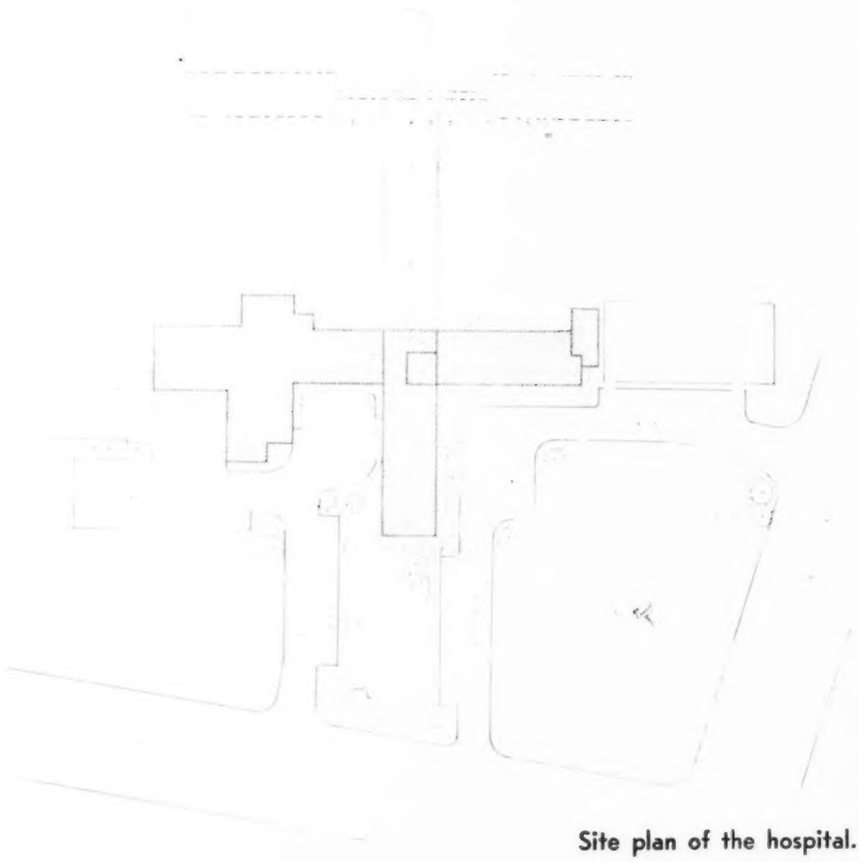
Below: Plan of the first floor showing relation of the service wing which is designed to provide ample light and air to such areas as laundry, kitchen and boiler room. Above: The second, third, fourth and fifth floors planned to conform with the architect's idea of arranging the hospital in nine units and placing identical units over each other.

to work in. The service wing also includes a coffee shop where food is served at reasonable charges to nurses, doctors and visitors. There is a dining room for the kitchen and laundry workers and a staff dining room used only by the Sisters. Separate kitchens or pantries have been placed next to these rooms. Food service to the patients is accomplished by means of trays loaded into heated trucks in the main kitchen and wheeled directly to the elevators and the rooms above.

In planning the main part of the hospital, it was found that the program called for nine units, all of approximately the same size. I studied these nine units separately and then arranged them in proper position with respect to the stairs and elevators where they would be furnished with the greatest amount of light and air. The nine areas include an administration unit; a unit for diagnostic or clinical facilities on the first floor; a surgical unit with a nursing unit on the second floor; the obstetrical unit with its nursing unit on the third floor, and three additional nursing units on the floors above. It was necessary to make the building four stories high in some places and five stories in others to accommodate these nine units and to place identical facilities directly over each other.

The administrative unit includes the general entrance and lobby; the business office, admitting rooms and emergency surgery; an ambulance entrance





Site plan of the hospital.

close to the admitting department; a doctors' entrance easily controlled from the telephone; a telephone room; a room for the staff; its library, the record room, and a resident doctor's bedroom. The second first floor unit groups the x-ray department, laboratory, the pharmacy and their related rooms around a separate waiting room where outpatients and others requiring the facilities can reach these services without entering the main lobby. These rooms are also well served by the elevators and the radiologist can quickly reach the surgical department by means of a stairway at the end of his suite. The air conditioning equipment for this suite, the surgery and the obstetrical units is placed at the end of this wing.

The surgery on the second floor includes all normal features with two major and two minor operating rooms. The obstetrical department is almost equally divided by the wall separating the delivery section from the nurseries. Each nursery contains only the bassinets that one nurse can service and each of the four nurseries is served by a working area and is placed next to a small examining room.

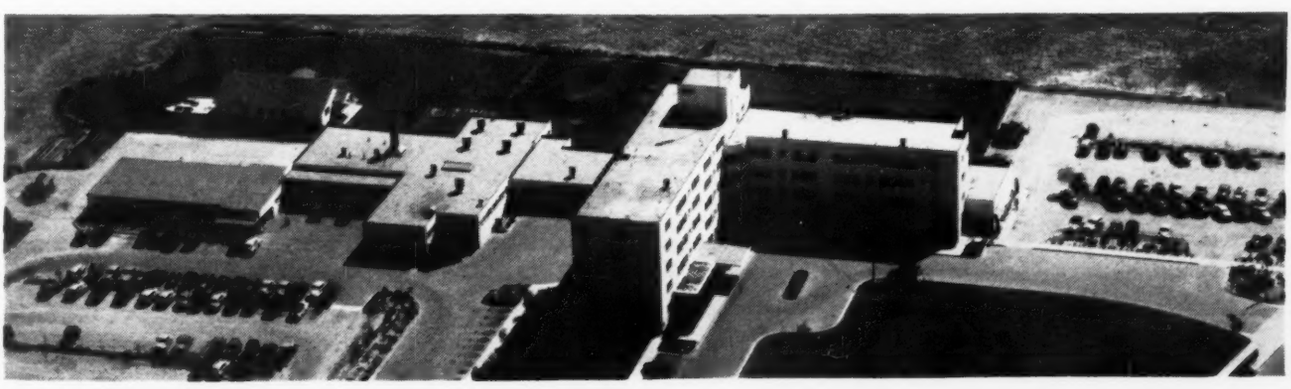
The nursing units each contain from twenty-five to thirty beds, these being considered the proper limits for the work of each group of nurses. All of the service rooms for nursing units were placed in the exact center of the area to be served. These rooms consist of a nurses' station with superintendent's desk and chart desks, medicine room, the utility room, a nurses' toilet, and lockers for the nurses assigned to that particular unit. In addition, there is a janitor's room with wheel chair and bed rack storage, a liquid nourishment room, a linen closet, a water cooler, and chutes extending through the entire building for both rubbish and soiled linens. All of these facilities are close to and under the direct supervision of the supervising nurse. Each nursing unit has a room that can be used for isolation, if necessary.

Construction is fireproof throughout with reinforced concrete walls, floors and roofs. Interior partitions are of metal studs with metal lath and plaster. Floors in general are all asphalt tile. In the operating and delivery rooms, terrazzo floors with a metal grid for grounding were installed with terrazzo bases and tile wainscoting. All walls are painted with bright, rather strong colors predominating. The ceilings are all acoustic tile of the slotted type with white factory finish and white borders. All windows are wood, double hung; doors are birch slabs. The building is heated by means of circulating hot water to convectors. Air conditioning has been provided in the obstetrical wing, the surgical wing and the diagnostic wing. Wherever gas is used, none of the air is recirculated.

In addition to the call system for patients, there are emergency buttons for the use of the nurse in case of trouble at each bedside and in the toilet rooms.

A public address system to all nurses' stations and various other central locations is used to call doctors and members of the staff.

Elevators are equipped for both operator and push button control. High and low pressure steam are piped to all equipment requiring the use of it. Telephone jacks are located at each patient's bed.



SMALL HOSPITAL FORUM

HOW THEY DIVIDE THE NURSING LOAD

THE extent to which hospital nursing service today is shared between graduate nurses and various types of auxiliary nursing personnel may be indicated in a recent survey covering thirty-seven hospitals in all sections of the country. Of 2292 persons engaged in bedside duties in this group of hospitals, 861, or 38 per cent, were graduate nurses.

The fact that 62 per cent of the nursing personnel in these hospitals is nonprofessional does not mean that 62 per cent of the nursing service is rendered by nonprofessional personnel, inasmuch as different classes of personnel carry different proportions of the nursing load, and at least one of these groups, the orderlies, commonly has duties outside the nursing department.

In the survey, administrators were asked to estimate the percentage of all nursing duties that could safely be performed by nonprofessional people. Among twenty-three replies, the lowest estimate was 15 per cent and the highest was 75 per cent. The average of all the estimates given was 48 per cent.

HALF HAVE NURSING SCHOOLS

As shown in the accompanying table, the hospitals were fairly evenly divided among the principal sections of the country. They ranged in size from twenty-five to 190 beds. The selection was random, with the exception that half the hospitals chosen had schools of nursing. As it turned out, two other hospitals in the group are operating schools for practical nurses, and a third offers on-the-job practical nurse training.

Of 1431 auxiliary nursing workers listed, 771, or 54 per cent, were student nurses (47 of these were practical nurse students). The student group thus constituted 34 per cent of the total nursing personnel.

The next largest group was the nurse's aides, with 398 aides working in twenty-six hospitals, half of which have schools of nursing. Nurse's aides constitute 17 per cent of the entire nursing group and 27 per cent of the nonprofessional group.

There were seventy-eight ward attendants and seventy-six orderlies at work in these hospitals—each group thus representing about 3 per cent of the whole personnel and 5 per cent of the nonprofessionals. However, there was wide variation in the distribution of these particular workers among the hospitals. Only ten hospitals had ward attendants, nearly half the total in this class being employed in one institution. On the other hand, twenty-six of the hospitals listed orderlies.

Six of the hospitals employ nursing clerks, one clerk in each of three hospitals and two each in the other three.

The average salary of graduate nurses on general duty in these hospitals was reported to be $197 a month, plus some maintenance—one or two meals and laundry in most cases. The only significant variation in salary practice from region to region that could be noted in this group of hospitals was that the Eastern area had more hospitals paying comparatively low cash salaries and providing full maintenance. By regions, the average graduate nurse salaries reported were: East $154; Midwest, $183; West, $206, and South, $177.

In addition to maintenance, student nurses in six of the eighteen hospitals with schools of nursing receive a cash stipend. The amount varies from $5 to $20 a month; the average is $12. In one of the two hospitals operating schools for practical nurses, students are paid $65 a month, plus maintenance, and students in the other practical nurse school get $30 a month, plus maintenance.

The average salary for the working practical nurse on hospital duty in these institutions is $128, or 65 per cent of the average salary for graduates. As in the case of the graduate nurse, one or two meals and laundry are usually added. The highest practical nurse salary is $176, compared to a high of $250 among the graduates. The lowest salary paid in both groups is $90 a month.

The average salary paid to nurse's aides in these hospitals is $100, plus one or two meals; this is approximately 51 per cent of what graduate nurses get and 78 per cent of what practical nurses are paid. The salary range for aides is $67 to $140. Ward attendants, with a range of $75 to $175, also average $100 a month, plus one or two meals. At $123, plus meals, orderlies are farther up the scale. So are the nursing clerks, whose average wage is $127.

GRADUATE NURSES SUPERVISE

In eleven of the thirty-seven respondent hospitals, graduate nurses supervise or work in teams with student, practical nurse or aide personnel, while in the remaining hospitals the auxiliary workers report directly to the head nurse or supervisor on the floor, working independently of the graduates. In three of the eleven hospitals using some kind of team combination, the auxiliary worker performs some of her duties as a member of the nursing team and others independently, it was reported.

One of the hospitals operating a practical nurse school reports the following arrangements for student, graduate and practical nurses and supervisors: On each nursing unit of approximately thirty patients, there is one graduate nurse on duty at all times. On the 7:30 a.m. to 3:30 p.m. shift, the graduate is assisted by six licensed practical nurses. From 3:30

NURSING SERVICE IN SMALL HOSPITALS

Hospital	Beds	Grad. Nurse No.	Grad. Nurse Sal.	Stud. Nurse No.	Stud. Nurse Sal.	Prac. Nurse No.	Prac. Nurse Sal.	Nurse's Aide No.	Nurse's Aide Sal.	Ward Attd. No.	Ward Attd. Sal.	Orderly No.	Orderly Sal.	Nursing Clerk No.	Nursing Clerk Sal.	Training Program	Drs'. Opinion of Nursing Service	Pct. Nursing Duties by Non Prof. Pers.	Nursing Cost	Grad.—Aux. Ratio
East	125	18	$145+	26	+			4	$ 74+			9	$108+	2	$ 74+	Aides				1–2.3
	190	40	170+	53	+			16	100+			1				Aides	OK		$2.34	1–1.7
	103	34	170+	10	+			14	100+			1	135+			Aides	OK	75	4.33	1–0.7
	133	53	130+			3	$100+	3	108	6	$ 75+	5	100+			Ward Att.		33	4.64	1–0.3
	116	42	160+	22(P)	$30+	3	100+					1	150			P.N.	OK	65	2.94	1–0.6
	56	16	170+			5	135+			2	125+	1	150+				OK	30	3.37	1–0.5
	76	25	150+	18	10+			4	65+									15	3.18	1–0.9
	25	10	140+			4	110+													1–0.4
Midwest	165	43	180+	102	+	4	125+	5	108+	19	90+	2	175+	1	155+	Aides	Pref. Gr.	25	3.32	1–3
	28	7	190			6	120+											50	2.11	1–0.9
	108	35	200	25	+			16	115			2	130			Aides	OK			1–1.2
	54	14	160+					4								Aides		75	4.54	1–0.3
	150	61	180+	27	+			35	95+			6	110+	2	110+	Aides				1–1.1
	150	46	190+	25	+			52	100+			5	120+	1	175+	Aides			5.50	1–1.8
	76	24	180	16	+			19	100			3	100			Aides				1–1.5
	63	7	170+			19	135+	9	140+			3	150+				N.G.	75	5.31	1–4.4
	110	40	185+	53	+			16	85+			8	133+			Aides	OK	35		1–1.9
	38	6	200			1	175+	10	130+							Aides				1–1.8
	50	10	175+			2	125+	22	90+			1	75+			Aides	OK		5.38	1–2.5
West	100	28	195					23	125			1	145				Fair	75	3.71	1–0.9
	120	30	225	32	+	15	185			4	175						OK			1–1.7
	25	3	180+			8	120+										OK			1–2.6
	114	25	190+					16	130+			3	150+			Aides		66	4.17	1–0.8
	30	8	250+					13	115+								OK	40	5.40	1–1.8
	47	9	222			8	176										OK			1–0.9
	135	10	200+	16	+	5	90+	2	75+	1	50+	1	125+			Aides	N.G.	33		1–2.5
	90	26	185	60	+	1	125	12	115			2	125			Aides		35	3.54	1–3
South	40	10	140+			2		2				3				Aides		30		1–0.7
	120	25	220	62	20+			35	120			2	40+			Aides	OK	75	3.53	1–4
	125	10	200+	61	20+					1	125+	1	150+					50		1–6
	190	50	200+	25(P)	65+	12	110+			9	75+	4	90+			P.N.	OK			1–1
	120	25	175+					48	100+			3	100+			Aides	OK	60	3.31	1–2
	30	7	170+			8	120+	2	80+	2	80+	1	100+			P.N.		50		1–1.9
	70	6	90+	36	5+													45		1–6
	30	5	200+			2	150+	10	67			1	100	1	100		OK			1–2.8
	100	15	190+	60	10+			6	75	2	110					Aides	OK	35		1–4.5
	150	38	190+	42	10+					32	100+	6	160+	2	150+	Ward Att.		25		1–2.2
Total		861		771		108		398		78		76		9						1–1.7
Average	93	23	$197+	38	$8+	6	$128+	15	$100+	8	$100+	3	$123+	1	$127			48	$3.92	1–1.9

+Plus maintenance.

to 11:30 p.m., the graduate on duty works with four student practical nurses, and from 11:30 p.m. to 7:30 a.m., the unit is handled by a graduate and two ward attendants.

In addition to these nurses and auxiliary workers, one supervisor is assigned to every unit from 7:30 a.m. to 3:30 p.m. On the other two shifts, two supervisors share responsibility for the six nursing units in the hospital. "Surgical patients stay in a special postoperative recovery room for twenty-four hours," the administrator at this hospital adds in further explanation of the nursing service breakdown. "One graduate nurse is on duty there at all times, assisted by two licensed practical nurses from 7:30 a.m. to 11:30 p.m., and one practical

(*Continued on Page* 118.)

TEACHING PLAN FOR HOSPITAL AIDES
(Corning Hospital, Corning, N.Y.)

FIRST DAY:
Morning—2 Hours—Classroom:
(Greeted by Director of Nursing)
I. Introduction to hospital routine
  A. Physical examination
    1. Aides' part in this routine
  B. Uniform
II. General appearance as a whole—personal hygiene
  A. Stress especially: Nail polish
    Hair nets
    Gum chewing
  B. Care of hands, face, nails, hair, mouth, body odors
    Posture
    Feet care—shoes
III. Explain errands—type
    Where
    Different departments
IV. Hospital housekeeping
  A. Linen regulations
  B. How to store linen in linen room
V. Serving of trays to patients
  A. Half-hour lesson on preparation of patient for meal
  B. How to feed patient
  C. Collection of trays
  D. Practice actual serving of trays to patients under supervision
Afternoon—2 Hours—Classroom:
I. Demonstration
  A. Cleaning units
  B. Making empty beds
II. Practice in classroom
III. Ward practice—clean and make beds under supervision

SECOND DAY:
Morning—2 Hours—Utility Room:
I. Demonstration
  A. Care of equipment
  B. Use of sterilizers
II. Practice
Afternoon—3 Hours—Demonstration:
I. Patient out of bed
  Making bed
  Use of wheelchair
II. Practice

THIRD DAY:
Morning:
I. Practice on ward (under supervision) of all preceding lessons
Afternoon:
I. Demonstration
  A. Morning care of patient in bed
    1. Care of hair, nails, etc.
II. Three hours' practice

FOURTH DAY:
Morning—3 Hours:
I. Repeat demonstration
  A. Morning care
    1. Incorporate making bed with a cradle or special pillow arrangement
  B. How to move and make patient comfortable
    1. Practice
  C. Practice under supervision on floors
Afternoon—3½ Hours:
I. Demonstration
  A. Morning care with bed bath and use of binders
II. Practice

FIFTH DAY:
Morning—3 Hours:
I. Demonstration
  A. Assistance in preparing patient for O.R.
    1. Making ether bed
    2. Bathing patient
    3. Different ways to make patient comfortable
Afternoon:
I. Practice all procedures taught to date
  A. May practice on ward under supervision

SIXTH DAY:
Morning—2 Hours:
I. Demonstration
  A. P.M. Care
    1. Special back care
    2. Mouth care
II. Practice—remainder of morning
Afternoon—Actual practice on floors under supervision

SEVENTH DAY:
Morning—1½ Hours:
I. Demonstration
  A. Giving and taking: Bed pans
    Urinals
    Output
    Collection—Specimens
II. Practice
Afternoon:
I. Ward practice under supervision

EIGHTH DAY:
Morning—2 Hours:
I. Demonstration
  A. Hot water bottle
  B. Ice cap
  C. Draping of patient for examination
II. Practice
Afternoon:
I. Ward practice under supervision

NINTH DAY:
Morning:
I. Demonstration
  A. T.P.R. (1 minute)
II. Practice
Afternoon:
I. Practice on ward under supervision

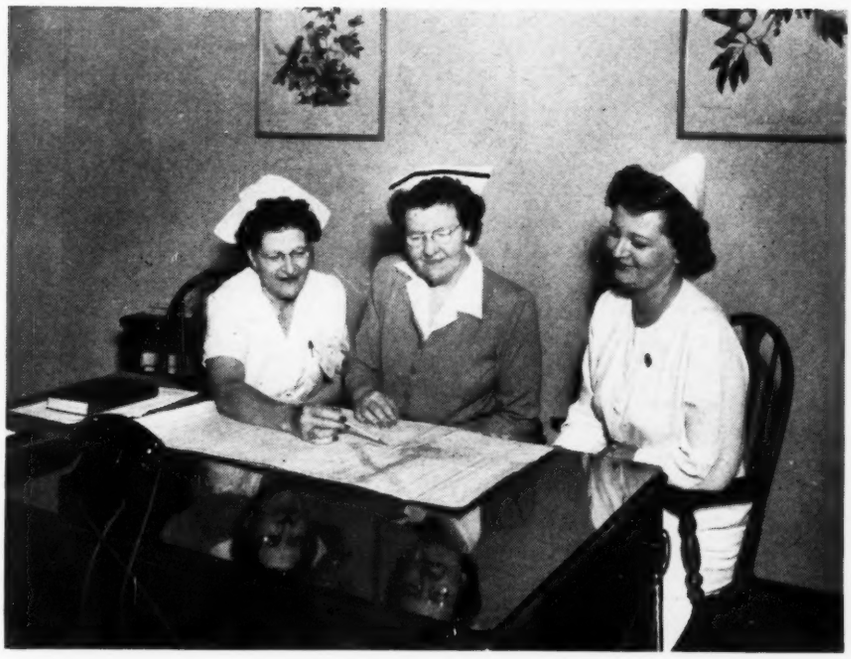
TENTH DAY:
Morning—1½ to 2 Hours:
I. Demonstration—admission and discharge of patients
  A. Check clothing
  B. Check valuables
  C. Collection of any type of specimen
II. Practice
Afternoon:
I. Practice on ward under supervision

ELEVENTH DAY:
Morning—2 Hours:
I. Demonstration
  A. Shampoo
  B. Treatment—pediculosis
II. Practice
Afternoon:
I. Practice on ward under supervision

TWELFTH DAY:
Morning—1½ Hours:
I. Demonstration
  A. Postmortem care
    1. Assistance to nurse
Afternoon:
I. Practice on ward under supervision

THIRTEENTH DAY (OPTIONAL):
Morning:
I. Demonstration of care of precaution patients (pneumonia, respiratory diseases) with reservations

OPTIONAL:
In six months—enema procedure
Two classes—three hours
Give two enemas in class before ward experience
Typewrite each of foregoing procedures in a simplified manner
To be given to aides after demonstration for reference



Nursing Office Comes Up to Date

RUSSELL C. NYE

Administrator, Northwestern Hospital, Minneapolis

A SAD situation sometimes needs a bit of caustic criticism. We attempt to recruit student nurses and to glamorize the profession, yet from their initial visit to the hospital until graduation, several years hence, these young women, in too many instances, have to study, work, live and play in overcrowded and cramped surroundings.

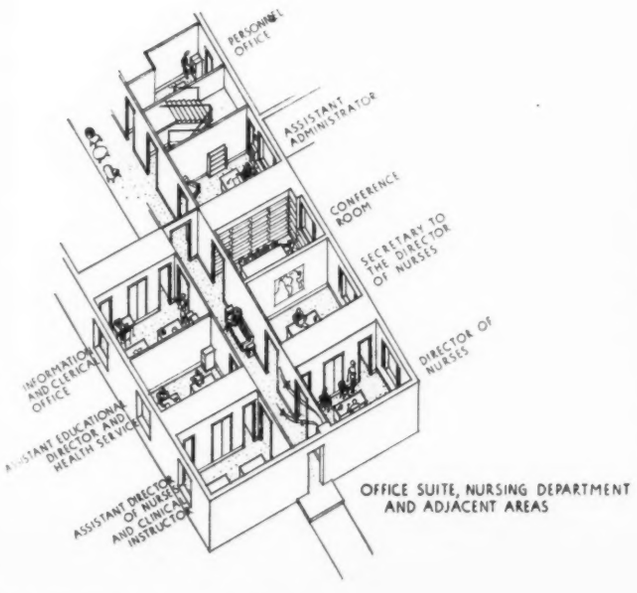
To take a positive and a constructive approach to the problem in our own hospital, where as many as four members of the nursing administration and faculty had desks in one room, the director of nurses proposed moving to a new suite of offices. That was first a shock, then a challenge. The director of nursing convinced us that under such conditions it was impossible to do any work that required periods of concentration because of constant interruptions. If anyone needed to concentrate it was necessary to go to the library or any place where quiet could be found. This was often undesirable because necessary materials were not at hand and the atmosphere was not always conducive to concentration. Observation indicated that there were constant interruptions because the traffic in the office was heavy. This slowed efficiency and reduced the output of work of each faculty member.

There was a constant necessity to perform duties or take calls for other people in the office. The telephone was not always available with so many needing to use it.

Further, a dignified office atmosphere was difficult under such circumstances. There was no place for graduate nurse or student to wait for interviews. There was no opportunity for conferences in private, only in secretive whispers. The result was obvious. Students and personnel were reluctant to come into the office for confidential conferences. No one was satisfied after the conference. On the one hand, no nurse wanted her problem to become common knowledge and be put on the grapevine; on the other, the staff was not satisfied that it had elicited a complete picture of a situation.

The board and administration finally came to a realization of the miracle that was being performed under these adverse conditions. Quickly, one wing on the first floor of the hospital was evacuated of interns and residents. More space was allotted to them outside the hospital proper. Their library in the hospital was revitalized by staff interest, and now a good recreation room and facilities are under way under the auspices of the doctors' wives.

Meantime, their old quarters were redecorated to house the nursing office suite. Fluorescent lighting was installed, and pleasant waiting room



Above: Dorothea I. Glasoe, director of nurses (center) confers with Mrs. Juanita Woodward, assistant director (left) and Barbara Anderson, assistant director of nursing education. Left: Isometric drawing of the new offices.

accommodations with piped in music were provided. In addition to increased and more attractive office space, a conference room was made available for all in the suite, which is located adjacent to the personnel department and paymaster's office.

All of us renewed our philosophy of education by adopting an attitude of continuing adjustment toward education and its problems. Special emphasis is placed on the purposes or goals to be achieved and the methods by which they are to be reached.

All of this took place a year ago. The first adjustment resulted in making the environment more suitable for good work and better health. The process of adjustment continues to take place on progressively higher levels, each leading to a greater measure of poise, dignity and efficiency, to better discipline, and to better integrated, happier and richer personalities in the administration, faculty and student body, and employes who came into contact with the nursing department. We have concrete evidence in this fall's incoming freshman class of nurses, sixty-five in number (ten more than our quota). In the face of difficult recruitment, the physical facilities of the nursing department have definitely "paid-off."

Your hospital and your school of nursing rank in the community with your church and schools. We must all meet the needs of a changing social order and adopt a philosophy to fit the culture of our times. Perhaps this story will suggest one way of overcoming some of our inadequacies.

Modern personnel practices are necessary to meet

THE NEW DEMANDS FOR NURSING SERVICE

HAROLD C. LUETH, M.D.

Dean
University of Nebraska
College of Medicine
Omaha

NURSING service is an intimate part of the medical service given in hospitals, public health organizations, industrial plants and community health agencies. As a result of increased interest in medical care, advances in medical science, extension of Blue Cross and other volunteer hospital plans, there has been a tremendously increased demand for nurses, a demand that can be met only by accepting new procedures and technics. Hospital administrators will have to face the new demands for nursing by utilizing modern personnel practice, including job classification and analysis. It is generally accepted today that nonprofessional workers will have to be employed to a greater extent than in the past, thus making it possible for the graduate nurse to spend more time at strictly professional work.

Years ago, practical nurses were often used in homes to assist in giving nursing care. With the increase in medical knowledge and the development of the nursing arts and sciences, the practical nurse was largely superseded by the well trained graduate nurse. Further scientific developments and accomplishments have increased the quality of nursing sciences to such a point that several states have considered the utilization of the practical nurse or ward helper. In New York, Virginia and Wisconsin and other states, practical nurses are recognized by law, and their training and licensing are prescribed by suitable regulations.

MANY DUTIES NONPROFESSIONAL

An analysis of the work usually done by the average nurse reveals that nurses are called upon for many nonprofessional duties. The employment of medical secretaries and clerks to compile histories, fill out the necessary requisition and order blanks, aid in the charting of the patients' temperature, pulse and respiration, and other such tasks can save a tremendous amount of time for the graduate nurse.

Programs of this type, utilizing ward assistants or practical nurses, allow the graduate nurse to spend more time with the patient and hence become a more effective nurse. Also, the graduate nurse is afforded more time for the instruction of student nurses in actual bedside and ward teaching. Practical nurses often help by doing some of the less technical procedures and more menial tasks, including the bathing of patients, changing bed linens, assisting the patient to the bathroom and wheel chair or taking him to the department of radiology or the clinical laboratory for examinations. With assistance of this type the graduate nurse can become a more efficient worker, thus saving the hospital considerable time and expense.

Another profitable means of saving nursing time is through the proper arrangement of supplies and materials. In the larger hospitals, supplies in general use should be kept in about the same location on the several wards throughout the hospital. An efficient central supply is also an effective means of saving the nurse's time in preparing and sterilizing apparatus and equipment. For example, five or six student or graduate nurses might be required to spend their time boiling needles and syringes in as many wards throughout the hospital—a task that could be more effectively performed

at the central supply department by one nurse. One or two ward assistants or general utility girls could be used to distribute the sterile supplies from the central supply room to the proper floors or wards.

A sound educational program for student nurses under a competent instructional staff has long been recognized as a valuable means of giving better nursing service to patients. Unfortunately, there has not been a general recognition of the value of training programs for the graduate nursing staff. Superintendents of nurses and hospital administrators should accept their responsibility of leadership in evolving satisfactory in-service training programs for graduate nurses. Newer technics, recent advances in the medical sciences, and a review of current nursing literature are all integral parts of a stimulating and successful training program for graduate nurses.

Coincident with the training program there should be a continuous appraisal of those taking the work. Often, latent capabilities and hidden talents are discovered during in-service training courses. As soon as it becomes apparent that new qualifications are uncovered, the graduate nurse should be interviewed and the possibilities of a new assignment should be discussed with her in a private interview.

STIMULATES STUDENT'S INTEREST

Other benefits of training courses are the stimulation and interest the student receives as a part of the opportunity to learn new things. Participation in a review course frequently makes the nurse feel that she is a part of a living and growing institution. Much of the boredom of deadly, daily routine is dissipated during active participation of a teaching course concerned with newer aspects of modern nursing practice. Even graduate nurses who do not join in a training program must admit the hospital is offering something for their advancement.

Not all hospitals are equipped to give training programs. Hospitals that cannot give in-service training should encourage their nursing personnel to seek training elsewhere. Too frequently, there has not been sufficient encouragement from hospital officials. It is believed that there should be a definite allocation of time for a graduate nurse to take additional courses at hospitals other than the one at which she is employed. At the time of the employment interview and at semi-annual or quarterly personnel interviews, a definite statement should be given the graduate nurse of the leave of absence allowed for the postgraduate training.

Special training should be recognized in certain fields, as obstetrics, pediatrics, orthopedic surgery, psychiatry and other phases of nursing. Wise administrators are alert to new sources of special talent and are quick to assign them to proper positions. Except for brief periods it is injudicious and wasteful to attempt to place specially trained and skilled personnel in general nursing assignments.

DON'T HOARD NURSES

Hospitals that do not have positions commensurate with a nurse's training should recognize the real situation. At times, hospitals have attempted to hoard personnel by keeping well qualified women in positions that were largely general nursing service. Such practices are inefficient as regards the hospital, unfair to the individual nurse, and have reflected an antipathy to the profession that has made some girls hesitant about entering nurse training.

Throughout the nursing service of the hospital there should be an almost continuous review and reclassification of nurses. Merit should be recognized and rewarded at all levels insofar as is possible. Head nurses who perform their duties with efficiency and poise should be rewarded. Pay adjustments should be realistic enough to compensate for exceptional services.

There has been a disposition on the part of some hospital administrators to move an exceptionally good head nurse to an administrative post as the only way of repaying her for her services. Some unusual head nurses or operating room supervisors have been transferred to positions they neither liked nor were capable of filling merely to reward them financially. Hospital managers and directors of schools of nursing should avoid such losses of professional skill and realize the resulting inefficient administration that often carries a wake of dissatisfaction to many graduate nurses.

Nursing will have to be made more attractive to young women in the future. Some college women who are unhappy or misplaced in various courses should be acquainted with the possibilities of continuing their academic training by entering an acceptable school of nursing. Courses in schools of nursing should be thoughtfully reviewed to ensure that they both teach the essential features of nursing and simultaneously challenge the student intellectually. A more direct appeal along accepted university teaching principles can be added with profit to courses in nursing. Much of the older prejudice of vocationalism and trade school technic will be dissipated by these new approaches.

Many directors of schools of nursing appear to be discouraged at the slender prospects of attracting girls to schools of nursing. Nursing is and long has been a valuable profession of service to humanity. While it is admitted that certain extramural features may momentarily lure the unwary, they are hardly to be recommended as a sound or long-range operating policy. The proper education of a nurse includes a program of serious study comparable to other courses of university training. Some have felt that it is essentially a vocational course and should not be considered in the same light as other academic fields.

STANDARDS ARE HIGH

A review of the curriculum recommended by the National League of Nursing Education and the American Nurses' Association leaves no doubt as to the high standards of current courses for student nurses. The proper nursing education at the bedside, in the operating room, in the supervisory conduct of other nurses, or in the instruction of ward attendants and nonprofessional personnel is the realistic implementation of collegiate training. There have been difficulties in hospitals and schools of nursing in the past. The life of a nurse has not always been the easiest and pleasantest nor has her remuneration been the highest.

It is significant, however, that despite past vexations and uncertainties one motive has made nurses carry on through the years. That motive is the ideal of service. Adjustments undoubtedly will have to be made to meet the economic and social conditions of the day. Nurses should be aware and proud of the fact that their chief heritage is that of service. Women of the type who should become the nurses of the future will be attracted by the opportunity of giving effective service to the community. The appeal to service and to professional care of the patient will be the most stimulating and rewarding method of obtaining the kind of women we want to be nurses of the future.

FLOATING CLINIC

Brings Health to Alaska

GEORGE W. GRUPP
Washington, D.C.

M/S Hygiene—Alaska's Floating Clinic.

THE first permanent floating public health and medical center of Alaska became a reality on June 19, 1948. This floating clinic is equipped to give complete public health service and to render emergency dental, medical and surgical services to the people living along the coastal mainland of Alaska and her countless isolated and remote islands, from Dixon Entrance of the Alexander Archipelago in the south to Attu Island in the west and to the islands of Bering Sea in the north.

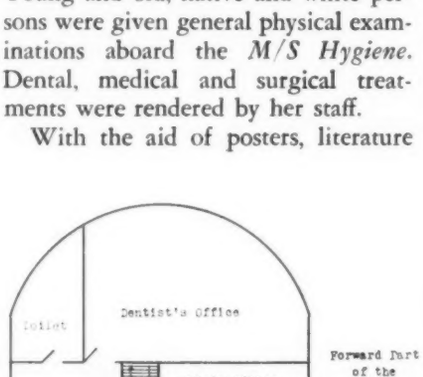
The establishment of this floating clinic is a great step toward improving the health conditions in Alaska. Oscar L. Chapman, Under Secretary of the Interior, put it this way: "The state of health of the people of Alaska has always been a matter of deep concern of the Department of the Interior; it is a matter of increasing importance if the development of Alaska is to continue and flourish. The Territory of Alaska has initiated and is conducting an intensive tuberculosis control and hospital program in order to curb a tragically high tuberculosis death rate. This program has been handicapped in the past by the inadequate and overburdened medical and hospital facilities and the inability of public health services to reach the many isolated areas of Alaska."

One of the first steps taken to reach these isolated areas of Alaska was the acquisition of the *M/S Hygiene* on a loan basis. She is the former *FS-35*, a 115 foot, twin screw, army wood combination passenger and cargo motorship with a maximum speed of 12 knots, built in 1943.

After the army lent her to the Alaska Department of Health in January 1946, she was converted into a floating clinic, at a cost of $30,000, by the Alaskan Territorial Health Department.

During the first eighteen months of her operation, on a loan experimental basis, more than 15,000 persons were treated in her clinic as she paused at about sixty different communities, which ranged from fishing villages of two or three families to towns of 5000 persons. During this period about 14,000 x-ray examinations were made. Young and old, native and white persons were given general physical examinations aboard the *M/S Hygiene*. Dental, medical and surgical treatments were rendered by her staff.

With the aid of posters, literature and a 16 mm. sound projection machine, the people of the ports of call were instructed in nutrition, infant care, dental care, sanitation and in the care of tuberculosis.



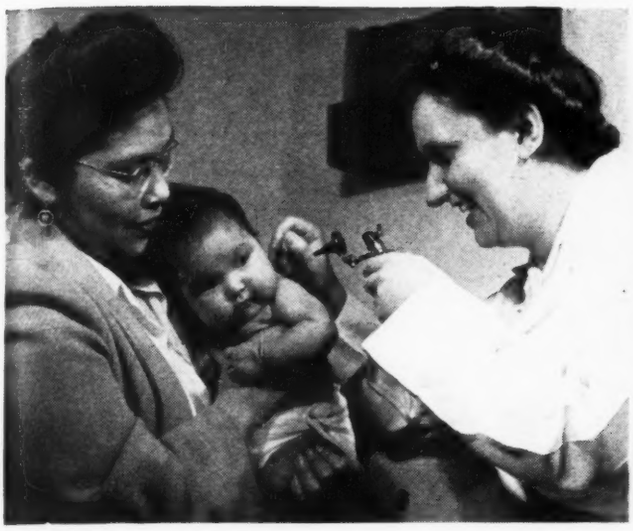
LAYOUT OF M/S HYGIENE'S CLINIC

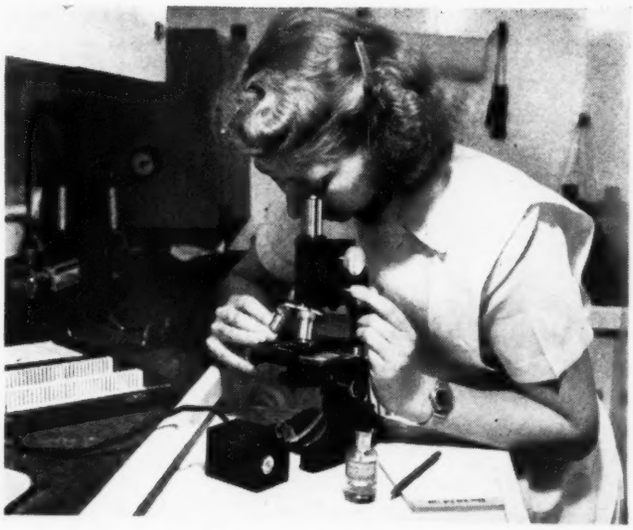
In addition, the clinical staff of the *M/S Hygiene*, with the aid of the vessel's facilities, assisted the sanitation and engineering division of the Territorial Department of Health in its consultation, educational and inspection work dealing with water supply and pollution, sewage disposal, food handling, industrial hygiene, and other public health problems.

In referring to the experimental operation of the *M/S Hygiene* on a loan basis, from June 3, 1946, to June 19, 1948, Mr. Chapman made the observation that "the principal value of the *Hygiene* has been the fact that for the first time in the history of the Territory a public health program on a mass scale has been made available to remote and isolated areas of Alaska."

The full significance of this observation is not easy to realize until one remembers that Alaska is a vast, mountainous, rugged country of 586,400 square miles with a mainland coastline of 6243 miles, and with thousands of islands and islets scattered along an arch about 3000 miles long. The great distances between inhabited points on the coastal mainland and on the islands have made the *M/S Hygiene* a gift of God to the isolated people in need of dental, medical or emergency surgical treatment.

The imperative need for this floating clinic for Alaska becomes clearer when it is recognized that corneal opacities are prevalent among the natives, that venereal diseases have be-





Above, left: Baby casts a wary eye on the otoscope; right: technician making microscopic examination. Below, left: Patients go aboard ship for treatment; right: the doctor demonstrates the proper use of a toothbrush. Bottom: Dental examinations are important to health.

come increasingly serious medical problems because of the influx of military and civilian construction personnel, that 20 per cent of the mortality in Alaska during 1945 (359.1 per hundred thousand as compared with 40.1 per hundred thousand in the States) was due to tuberculosis, and that a recent report made by a board of medical men, representing the American Medical Association, revealed the inadequacy of sanitation facilities in Alaska as shown in the table which appears on page 60.

Faced with such a need for sanitation facilities, and with the problem of great distances between isolated inhabited places which have either no hospital facilities at all or inadequate ones, the promotion of good health in Alaska would not make much progress without the *M/S Hygiene*.

It was only through the untiring efforts of Congressional Delegate E. L. Barlett of Alaska, Territorial Governor Ernest Gruening, Alaskan Health Commissioner Dr. C. Earl Albrecht, Interior Secretary Julius A. Krug, and others, that a measure was passed by the 80th Congress, signed by President Truman on June 19, 1948, which authorized the transfer of the *M/S Hygiene* from the army to the Territory of Alaska as a permanent floating clinic.

At a total annual cost of $70,500 the *M/S Hygiene* goes on errands of mercy for the Department of Health of Alaska. Toward this total cost funds are contributed by the United States Children's Bureau and by the Alaska Native Service.

The itinerary for each of her six-month cruises is carefully laid out by the physician in charge of the clinic, by the captain, and by the administrative staff of the Territorial Department of Health. During each cruise constant contact with Juneau is maintained by radio.

The *M/S Hygiene* is manned by a captain, a mate, a chief engineer, an assistant engineer, two deck hands, a cook and a mess boy, all of whom are

AVERAGE PER CENT ADEQUACY OF SANITATION FACILITIES

Judicial Division of Alaska	Water Supply	Sewerage	Garbage Disposal
I Southwestern	59.0%	38.0%	29.0%
II Arctic and Bering Coastal	2.5	0.5	3.0
III Southern Pacific Coastal	22.0	18.0	17.0
IV Interior	7.5	11.0	10.0
Entire Territory of Alaska	30.0	20.0	17.0

experienced in the navigation of the uncharted shoals and rock strewn channels of Alaskan waters.

Her clinic is staffed by a physician, a nurse, a laboratory and x-ray technician, a dentist, a dental hygienist and a medical secretary.

In the clinical section of the *M/S Hygiene,* the waiting room, the public toilet, the dentist's office, and the medical secretary's office are located on the main deck. The doctor's office, the nurse's office, the nurse's exhibit room, the dressing room, the clinic room, the medical laboratory, the x-ray contact booth, x-ray room, and darkroom are located on the lower deck.

When the patients come aboard the *M/S Hygiene* they first go to the medical secretary's office. Here the secretary and volunteer workers record on cards the patients' names, ages, races and marital status. When this is done they are given x-ray, immunization, dental and other service slips. In the secretary's office are kept the case histories according to villages, names and races, such as Aleutian, Eskimo and Indian.

The waiting room, which adjoins the medical secretary's office, has adequate wall benches for those awaiting their turn for examination or treatment. As they wait, adults and children are provided with health literature and health comic books. The walls of this room and those of other public rooms of this floating clinic are decorated with instructional illustrated posters on nutrition, hygiene, child care and other public health subjects.

The dentist's office is equipped with such essentials as a chair, a dental unit, an x-ray machine, instruments, drugs and supplies.

On the deck below, the doctor's office is outfitted with all essentials, including a small library.

The clinic room is always a beehive of activity when at a port of call. In this room expectant mothers are examined, weighed and instructed. With visual aids, parents are instructed in the bathing, care and proper feeding of babies. Here, as well as in the dressing room, all child patients are immunized against diphtheria, typhoid fever, small pox and pertussia. As the children are examined, or treated, the parents sit close at hand to calm the hearts of the little ones. Here both young and old are given routine general physical check-ups. Ears are examined and drained when necessary. Eyes are examined and treatments are prescribed. And all are instructed in hygiene and nutrition both here and in the nurse's exhibit room.

EQUIPPED FOR EXAMINATIONS

This clinic room is equipped with a gynecological table, a cabinet with the necessary instruments to perform gynecological, obstetric, neurological and audiological examinations, and a wall cupboard with drugs needed for general clinical and emergency work.

In the nurse's office there are a small library and files filled with health literature which is distributed among the patients.

The x-ray room is located across the passageway from the clinic room. This part of the clinic is made up of three rooms, namely, the x-ray control booth, the x-ray room and the darkroom.

The darkroom is provided with supplies and equipment for the development of x-ray films. The modern development tanks have buckle-down tops to prevent splashing when the ship rolls or pitches. A 14 by 17 inch film can be dried within an hour by the darkroom's special fan drier.

For the taking of x-ray pictures a photofluorographic 500 milliampere unit is used. This machine is capable of taking 4 by 5 inch chest and 14 by 17 inch skeletal and chest x-ray pictures. It is powered by a 90 horsepower diesel engine and 37.5 KW generator, which are located on the fantail of the vessel.

The clinic's medical laboratory has a powerful microscope with lamp and accessories, a cupboard with chemicals and other supplies, a small library, a centrifuge, a built-in sink, an incubator and other essential equipment. In this laboratory, the staff makes sputum tests, hemoglobin determinations, blood counts, venereal disease darkfield examinations, urine analyses, smear tests, water supply tests, and sewage disposal tests.

The Contribution of Social Case Work

PRIVATE A, a 19 year old soldier, had been hospitalized for rheumatic fever. Because of his indifferent attitude and inability to follow medical direction, the ward medical officer suggested to the social worker that perhaps she could interest the patient in something or possibly learn more about the reasons for his attitude.

After several interviews, it was learned that although the patient had been given some medical interpretation, he had built up innumerable fears regarding his illness, such as fears of heart failure and fear of continued invalidism. The worker presented this information to the doctor. When the patient was given a better understanding of his condition by the doctor, there was a resultant change in his actions and attitude, and he began to make plans for the future and to participate in diversional activities. At this point, his parents came to visit him, and suddenly there was a decided reversion on the part of the patient to his former attitude.

The social case worker closely observed the family relationships and noticed that its attitude was one of over-concern and over-protection, and any effort made by the patient to do something for himself was met by "you must not exert yourself," or "let us do that for you." It was decided that the family, too, needed a better understanding of rheumatic fever. In talking with the parents, the worker was able to help them understand that their attitude was not helping the patient get well.—*From a Social Service Case Report.*

BOOKKEEPING METHOD FOR BLOOD BANKS

JOHN N. FRAZER

THE operation of the blood bank, insofar as laboratory technics are concerned, is a series of established methods. However, the records need much improvement. The methods presented here have had many advantages in a large blood bank located in a medium sized hospital, and the procedure is especially adapted to the voluntary blood banks.

The primary problems to be overcome were: (1) to rotate the blood in such a manner as to ensure comparatively fresh blood (under our plan the blood averages not more than two weeks before it is given to patients); (2) to keep records of the credits of blood units due to patients, each having one or more donors who had given blood to the bank for these patients, and (3) to set up records which would show the numbers of blood units on hand and reflect the surplus of blood available in the bank.

The handling of such records has been simplified by the adaptation of bookkeeping methods to the blood bank records. This has resulted in a saving of time, increased efficiency and accuracy of records. However, it must be emphasized that the purpose of these bookkeeping devices was primarily to keep the stored blood rotating in the bank and, simultaneously, to increase the surplus of the bank. It is possible to ascertain the blood surplus (blood units not due to any patient) at a glance.

The blood bank book used in this bank employs only three forms. These forms are shown in figures 1 and 2. A three-ring looseleaf notebook makes an excellent file, and the use of index tabs saves considerable time. The forms can be cut on stencils for rapid and economical reproduction.

The divisions of the book are: (1) donor register, (2) blood group O, (3) blood group A, (4) blood group B, (5) blood group AB.

Figure 1 shows the only form used in the donor register. Figure 2 shows the left and right hand pages of the blood group sections. The records book should contain only the pages in actual use, the filled pages being filed in the back of the book.

An illustration to show these new methods in actual operation will make them clearer to the reader.

Jack Smith came to give a pint of blood for his wife. The entry was first recorded in the donor register (Fig. 1). He was a blood group O. The unit of blood was given the number 1000, and a pint taken from his son was given the next consecutive number, 1001. The check columns are not utilized at the time blood is taken from donors; this indicates that these units are not as yet transferred to the blood sections of their respective blood groups and no credits have been given to the intended recipients.

In this system all blood groups of specific types are numbered consecutively according to series or code numbers. Thus, we give blood group O units the series numbers 1000, 1001, 1002 on through 1999. Similarly, blood group A has the numbers 2000 through 2999; B has the series 3000, and AB has the series 4000. These series could be changed later to 1000-A, 2000-A, 3000-A and 4000-A, respectively.

The bank can take care of a number of blood donors at one time with a minimum of record work. When time permits, the entries can be carried to the blood group forms. In figure 2, the first entry on the left hand page is the number 1000, the number of Jack Smith's blood. When this entry was recorded a check mark was placed in the third column of figure 1 on Jack Smith's entry. This shows the entry has been recorded on its respective blood group form.

The fifth column of figure 1 is used to carry entries over to the right hand page of the blood group forms (Fig. 2). When this was done, a check mark was placed in the sixth column of figure 1. The many credit columns are provided to show units of blood due to the patients, and change with blood given to the patient or blood taken for him. Thus it may be seen in figure 2 that Mrs. Smith has two pints of blood in the bank. The debit balances are for blood given to patients who have no credits and therefore owe the bank some blood.

FIGURE 1: The only form used in the donor register. Entries include names of donors, with blood group and code number, the names of the patients, date and comment.

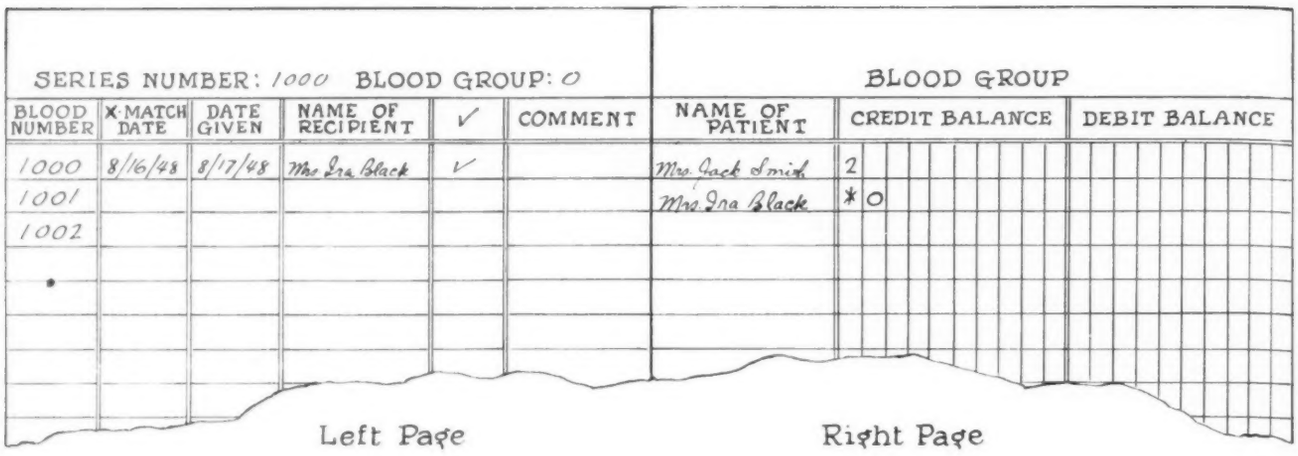


FIGURE 2: Left and right hand pages from blood group sections of book.

Let us suppose the doctor orders one pint of blood on August 16 for Mrs. Ira Black, to be used the following morning in surgery. The cross-match date, implying the blood is compatible with Mrs. Black's, is shown in figure 2. When the blood is taken to the surgery, the date is marked in its proper column in figure 2.

This bank has to record transfusions given on the patient's laboratory report card. Charges for services rendered are made from this card. When these data are recorded, a check mark is placed in the fifth column of the left hand page of the blood group section.

The use of the check mark columns enables the person or persons in the blood bank to work steadily and transfer entries when time permits them to do so without relying on memory.

The blood usually to be given to patients is the specific type having the lowest number in the series, provided it is perfectly good and fresh blood. It will be noted from figure 2 that Mrs. Black was given blood number 1000. This rotation ensures comparatively fresh blood in the bank at all times. Also, the blood credited to Mrs. Black was reduced by one unit, leaving her no more credit.

The surplus in the bank for any specific blood group can be seen at a glance by the person in charge of the bank. The numbers on the left hand page of the specific blood group section show the numbers of units available or on hand (comparable to assets) if they have not been given out. The credits on the right hand page show the units of bloods due to the patients. The difference between these totals, if positive, represents the surplus blood on hand.

Telephone inquiries from the hospital floors, or from the family of the patient, can be answered in a minimum of time. A glance at the pages of the blood group possessed by the patient (we have a laboratory card index file near the telephone) will show all pertinent data.

These methods have enabled this bank to function efficiently and I hope that those having similar problems involving the blood bank will be helped by this summary of our bookkeeping technics.

The author wishes to express his grateful appreciation of the illustrations drawn by Genevieve Lee, medical artist.

ADMINISTRATIVE CAPSULES

1. GROUP MEDICINE is the easiest kind of medicine to swallow, as we see in the wards of our hospitals; it requires no sugar coating whatsoever.

2. MISPRINT: Doctors who object to group medicine prefer to charge patients on an individual feel basis.

3. IT COULD READILY BE ARGUED that the greatest menace to the safety and comfort of a patient in the wards of a hospital is the business manager type who "knows the price of everything and the value of nothing."

4. ORIGINAL IDEAS IN THE HOSPITAL and everywhere else are precious forms of personal property which differ from diamonds and rubies only in that they can give pleasure to far more people than the possessor himself. He who steals the credit for an original idea, no matter how well he applies it, is dishonest. In such cases we ought to be ready to call a spade a spade.

—E. M. BLUESTONE, M.D.

HOW MUCH IS AN ADMINISTRATOR WORTH?

JAMES R. GERSONDE

Administrative Assistant
Harper Hospital
Detroit

HOW much is the boss worth?" What is his value to the organization? These questions are asked by those who wish to hire the "boss," by those who work for the "boss," and by those who aspire to be the "boss."

What constitutes an adequate executive salary poses an important business problem. To develop a comprehensive plan in an effort to solve this problem would necessarily involve exhaustive research and analysis, and even after considerable investigation it is possible to consider only a few of the pertinent phases of compensation for executives.

A discussion of certain basic factors might well be considered, however, and may prove to be of value in analyzing the reasons—or lack of reasons—executive salaries differ almost to the extent of the individual differences of the executives commanding the salaries.

WHY THE VARIATION?

Why does the administrator of Hospital A, a 200 bed general hospital, command a salary of $12,000 a year and the administrator of Hospital B, the same type and size, command a salary of only $4000 a year?

The American College of Hospital Administrators has reported that there appears to be "no rhyme nor reason" for the salary variances of hospital administrators. As an example, the results of a survey conducted by The MODERN HOSPITAL[1] among 1021 nongovernmental general hospitals in the United States and Canada showed that in hospitals of twenty-five to forty-nine beds the salaries ranged from under $1200 a year to more than $6000 a year. This variance carried over into the hospitals of the fifty to ninety-nine bed range and the 100 to 199 bed range; even in hospitals of 500 beds and over the salaries ranged from $3600 annually to more than $15,000.

These salary differences resulted from various factors, of course. The responsibilities were not identical in each hospital, the financial conditions differed and the geographical location probably had some influence. The most important factor, however, was doubtless the individual differences of the administrators.

In the foregoing example, the administrator of Hospital A, in the opinion of his governing board, possessed certain abilities and traits which were worth $12,000 a year to that hospital, while the administrator of Hospital B was doing a $4000 a year job, according to the judgment of his governing board. The individual differences of these two men were apparent to the two groups judging the men, and from the group judgments the worth of each was determined in the light of the other influencing factors.

It is not always true, but generally speaking, within a particular field of activity an individual is compensated according to his worth to the company or institution that employs him.

How much a hospital executive is worth then becomes of primary importance to each person concerned with the hospital's sphere of activity. His compensation will be based on the value of his abilities to the hospital, and it is an accepted fact that "we rarely get something for nothing." The worth of the hospital executive is of great concern to the governing board. It is the board's moral and legal responsibility to determine his qualifications as indicated by the American Hospital Association in the "Code of Ethics" for approved hospitals. The code defines the duties of the governing board to include the following:

"To surround the patient with every reasonable protection, thereby fulfilling the moral and legal responsibility of the board, accordingly;

"(1) It is the responsibility of the governing board to exercise proper care and judgment in the selection of a qualified administrator."

The members of a governing board of a hospital must assure themselves that the administrator they have selected to act as their "executive officer" can direct the activities of the hospital toward the achievement of the objectives according to the standards set forth by hospital authorities.

How much then is the hospital executive worth?

The answer: "As much as is required to obtain the person, who, in the considered judgment of the governing board, can achieve the objectives of the hospital according to accepted standards."

CANNOT SET SCALE

This answer appears to be abstract and indefinite, but practically speaking, there is no set amount of money or even a salary scale that can arbitrarily be established to meet the requirements of each hospital. Hospitals are today meeting certain standards of professional care and in some cases are endeavoring to achieve standards of administration, but there can never be any real standardization of the executives who are responsible for the attainment of these objectives.

We must have some basis for payment of executive salaries, however, so what will that basis be?

In reviewing some of the executive salary plans in industry in an attempt

[1]Mills, Alden B: Hospital Salaries, Mod. Hosp. 54:58 (May) 1940.

to derive some usable procedures, one point is evident: there is no one plan that will be applicable for every type of company, even within a particular industry. This is particularly true of hospitals. Basically, any plan which hopes to arrive at some adequate basis for payment of executive salaries must be developed for the individual hospital and the objectives it is seeking to attain.

Dr. Harry A. Hopf of the Hopf Institute of Management, in his article "Executive Compensation and Accomplishment," states:

"Viewed from the essential perspective, executive compensation may be said to exhibit psychological, economic, social, legal, political and other aspects, notably in the fields of accounting and taxation, each of which must be given due weight in the construction, installation and operation of any plan if it is to be successful as an aid in the management of an enterprise and a powerful stimulus to increased accomplishments."[2]

MUST UNDERSTAND OBJECTIVES

This statement presents the complexity of determining adequate executive compensation. The solution lies not in an arbitrary plan or plans, even though well thought out and developed, but rather in a clearer understanding of the objectives of the hospital and the relationship among the groups concerned: the governing board, the administrator, the medical staff, the employes, the patients and the public, for all have an interest in the hospital's operation.

The modern hospital is "in business" to accomplish its objectives of: (1) care of the sick and injured, (2) education of physicians, nurses and other personnel, (3) public health, *i.e.* prevention of disease and promotion of health, and (4) advancement of research in scientific medicine.[3] The attainment of these objectives determines whether or not the hospital is meeting its obligations to the community and thereby justifying its existence.

"Care of the sick and injured" means the best possible care. The quality of hospital care is reflected in the education and training of professional personnel, the advancement of public health, and the research in scientific medicine. A general hospital, in order to meet its full responsibilities, must keep each of these objectives in mind. Too often hospital governing boards are satisfied with "reasonably adequate care of the patient" and lose sight of the other important objectives which must be accomplished in order to assure the proper hospital care.

With the objectives clearly in mind, it is then important that a well defined relationship exist between the governing board and the administrator if he as the hospital executive is to prove his worth. The board must entrust the director with the execution of all policies which it may establish. These policies are the principles and rules of action that guide the hospital to its objectives, and the administrator, acting for the board, must direct the activities of the hospital in conformity with these policies.

To fulfill his responsibilities properly, the administrator must be the executive officer for the governing board. As executive officer he is responsible for the entire hospital activity and so must possess special qualifications. He must have executive capacities and such traits as intelligence, courage, human understanding, receptiveness, originality, experience, teaching ability, tenacity, personality and a sense of justice and fair play.[4] Any shortcomings of the administrator may directly or indirectly be reflected in the ultimate care given to the patient, and hence he must be a person with the highest professional and moral standards.

The hospital patient has a right to expect the best possible care from the hospital. Human life and health are not measurable in dollars and cents, and the hospital must make every effort to provide the most effective medical care to each patient, regardless of cost. On the other hand, human effort must be guided effectively and efficiently so that the greatest amount of care can be rendered, as well as the best quality of care. The hospital's budget is usually limited and the hospital that provides the best quality of care to the greatest number of patients in the most efficient manner is the one that is truly meeting its objectives.

The employes, too, have a right to expect fairness and reasonable consideration from the hospital. The hospital is not always financially able to pay the highest salaries and offer the smallest number of working hours, but it must strive to give its employes good working conditions and reasonable compensation. No hospital can justify low wages to employes, even though it may be on a limited budget. This is especially true when the low salaries are paid to persons with little or no qualifications for the positions they fill. Many hospitals might well consider doubling the salaries of their executive positions so that competent personnel could be attracted that could in turn save the hospital many times the increased expenditures through good management and efficient administration.

The community should be able to look to the hospital as the proper agency to assist in the promotion of better health. The hospital should be the motivating force in health promotion projects of community-wide interest and should readily provide all possible assistance to existing public health agencies. A hospital whose budget will not permit this participation cannot justify its operation when it has not made every effort to assure itself that competent management is directing the activities. Too often we are "penny wise and pound foolish" when it comes to employing competent persons in hospitals and giving them reasonable remuneration.

With this understanding of what the hospital's objectives should be, and an appreciation of the managerial relationships necessary in the accomplishment of these objectives, some basic principles can be used in a determination of an executive salary plan.

Dr. Hopf has set forth six basic principles which any organization should seek to attain in connection with the payment of executive compensation generally, regardless of the type of plan used[2] These principles, altered here to apply to hospitals, are basically as follows:

The Governing Board

1. Should ensure that the best possible return is obtained from the dollar of pay roll disbursement.

2. Should make reasonably certain that the respective shares of ownership and management in the net result are equitably determined and apportioned. (The "ownership" of the hospital is in the community which it serves, and

[2]American Management Association, Financial Management Series No. 78.

[3]MacEachern, M. T.: Hospital Organization and Management. Chicago: Physician's Record Company, 1947.

[4]Davis, Ralph C.: Business Organization and Operation, 1937.

the governing board as the responsible body should not attempt to "save" money for the hospital by paying low salaries, since efficiency in management will provide an ultimate saving and management is entitled to fair remuneration.)

3. The total executive compensation should be kept within dimensions which will not prove burdensome in the long run. (It is important, too, that salaries are not higher than is consistent with good management.)

The Hospital Executive

1. Should, through the exercise of good management technics, assure the hospital an adequate and fair return on the performance of each individual by utilizing the respective abilities of department heads and other administrative personnel.

2. Must utilize to the full, and in the most efficient manner, the reservoir of energy represented in the executive staff.

3. Should supply the hospital personnel with a constant incentive to strive for increasingly satisfactory operating results.

There is no true answer to how much an executive is worth. When determining the value of a hospital executive all of the points outlined should be taken into consideration if an effective compensation plan is to be developed.

The operation of any plan, however, can be only as effective as the "goodness" of the hospital, that is, its organization, leadership, the definition of responsibilities and the indoctrination of the employes in the hospital's objectives.

Without proper leadership executive initiative may be stifled or confined to routine duties. Without good organization it is impossible to determine accurately the executive functions and the contributions made by good management. Without definite responsibilities overlapping of effort and lack of coordination will retard positive results. Without indoctrination the efforts will not be expended toward the real objectives of the hospital.

THE AGED FIND A HAVEN IN "THE ANNEX"

WILLIAM P. SLOVER

Superintendent, Manchester Memorial Hospital, Manchester, Conn.

AN IMPORTANT and pertinent problem now facing hospitals in both small towns and large cities is the influx of elderly patients requiring long-term hospitalization. This problem has been successfully met by the Manchester Memorial Hospital, Manchester, Conn., through the establishment of Manchester Hospital Annex, located two miles away from the main hospital.

Advances in medical research and available new drugs have prolonged life expectancy to 67 years for women, and 65 for men. When compared to life expectancy tables at the beginning of the century, showing 49 years to be a "ripe old age," this is a remarkable achievement. Accompanying the life expectancy jump, however, are the degenerative diseases of old age which as yet medical science has not been able fully to overcome. Whether it can solve this problem still remains to be seen, but American people, naturally optimistic and progressive, expect to find the answer. Therefore, if science finds the solution, present-day problems in caring for the aged will undergo a distinct change.

Manchester is proud of its ability to provide for the chronically ill as part of its overall hospital service. It took no small amount of courage in 1946 to establish this additional service in a separate building two miles away from the main hospital. At that time nurses and personnel were almost unobtainable. It took additional personnel to staff this new venture at a difficult time. Nevertheless, enough people in Manchester could see the need and were willing to work for the hospital and the chronically ill. Labor in Connecticut, as in other places in the country at that time, was in short supply and the fact that the annex has since been adequately staffed at all times has been a source of pride to all of us.

After a recent inspection, an official of the State Department of Public Health enthusiastically declared, "Manchester Hospital Annex is the best example of nursing care, ideal location and patient comfort for elderly folks that I have ever seen. I wish the same type of care might be offered throughout the nation by other hospitals in the United States which are faced by this ever-increasing problem."

This new annex was the former Anne Cheney house on Hartford Road. After Miss Cheney's death in 1944, the site and property were left to Cheney Brothers which generously leased it to the hospital in 1946.

The annex today is beautiful in its inheritance of artistic antiquity. The main hall and lounge room has white oak paneling, still in excellent condition, as is the white oak staircase with its unusual carved spindles. Suspended 15 feet from the ceiling in the center of the wide staircase is an old-fashioned, wrought iron lamp which was imported from Italy. This has been electrified, as have the unique wall sconces that decorate the main entrance.

The huge dining room, which has been turned into a men's ward, has a teakwood floor imported from India. The attractive library and former liv-

Photographs from the Hartford Courant.

"The Annex" was once the Anne Cheney house to which residents of Manchester pointed with pride. They still point with pride now that it is devoted to serving elderly patients.

ing room downstairs make pleasant ward rooms for the women patients.

The ceilings downstairs are a revelation. Constructed of plaster, they are elaborately designed, in the living room with ornamental Grecian figures, and in the other rooms with various intricate types of tracery.

All fireplaces had to be closed in to comply with fire laws. As a result, therefore, many of the old fireplaces, fashioned of marble and stone with carved birds, flowers and scrolling, have been converted to make serviceable linen and supply closets. Upstairs, the fireplaces have carved wood mantels. In the East Room is the George Washington mantel, taken from George Washington's headquarters in New York when the mansion was demolished. Made of wood, painted white, simply carved and supported on fluted pillars, the beauty of this early Colonial mantel is in its simplicity.

In obedience to the fire laws, the entrances from the stairway to the second and third floors have been closed by doors constructed of asbestos wallboard on one side and metal lath covered with cement plaster on the other. All fire hazards have been reduced to a minimum and an automatic overhead sprinkler system has been installed. An outside fire escape has been built on the south end of the building. Rooms on two floors open into large hallways or communicate with each other, or provide easy egress onto a porch roof running around the building.

Immense tiled bathrooms, equipped with a tremendous amount of closet space, are located on the second and third floors. Some of the bathrooms have foot tubs and all the original plumbing is in perfect repair.

The entire building is well heated with steam radiation from the central heating plant at Cheney Brothers' mills near by.

An interesting part of the cellar is a tunnel extending many feet underground through the yard. As the home was originally built on the brow of a hill, this tunnel was installed long ago so laundry could be washed in the basement, carried through the tunnel to the yard in the rear, and thus be out of anyone's view. The tunnel is no longer used as all laundry is done at the hospital laundry plant.

The original kitchen facilities at the annex lend themselves well to hospital requirements. The few changes made have included the addition of four electric refrigerators, a new gas stove and an electric dishwasher. It is surprising that the kitchen layout, plus cupboard space of long ago days, is still convenient for use today.

Meals are prepared by two cooks, husband and wife, who are responsible to the dietitian at the hospital. They are assisted by three full-time and two part-time maids. A dietitian spends an hour a day at the annex, discussing menus with the cooks and the charge nurse, also visiting patients. Likes and dislikes are recorded in the kitchen and each meal is thus adapted to the requirement of the individual.

Raw, perishable foods are delivered to the annex from the main hospital at 8:30 a.m. Staple foods are delivered in cases directly to the annex by the wholesale grocer once a week. Each afternoon the cook gives his order by telephone to the dietitian for delivery the next morning.

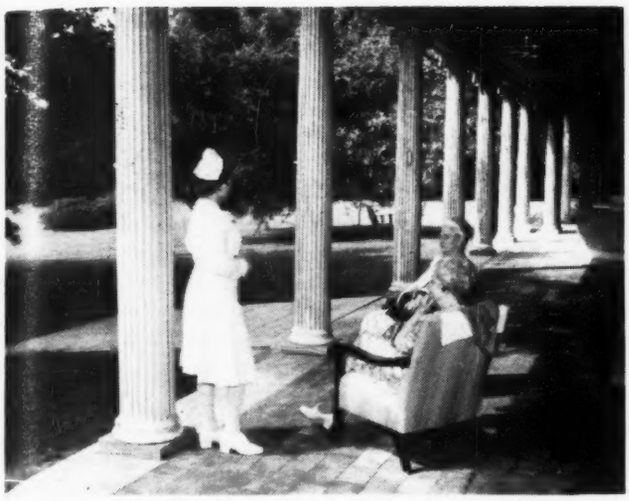
Nearly half of the patients have their meat and vegetables ground because of poor dentures. There are also a few diabetic and salt-free diets which are based on the regular menu. Private patients are visited daily and given their choice of foods.

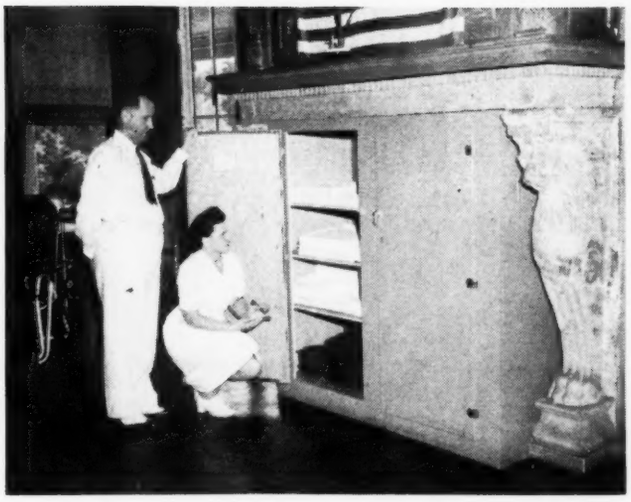
Full breakfasts are served of fruit, hot cereal, egg or bacon, toast and coffee. Dinner at noon includes meat, potato, vegetable, dessert and beverage. The elderly patients prefer a lighter supper than is served in a general hospital. Popular supper dishes are cheese soufflé, chicken noodle casserole, scrambled eggs, French toast, fruit salad plate, hot milk toast with a poached egg. Hot soup and a light dessert are included, with a salad for those who are more active.

Last summer the head cook planted a small garden with carrots, Swiss chard, potatoes and onions. Some of the more active male patients took great pride in helping to care for and harvest these vegetables. As a result, they more thoroughly enjoy their meals, especially when home-grown vegetables are served on their trays.

The opening of the annex for the care of the chronically ill and the long stay patient offered a real challenge to the nurses. Through all the war years, luxury nursing was the forgotten term. The patient admitted to the annex needs some luxury nursing—so both the necessary care and a touch of "luxury" must be provided. Both the long stay and the chronically ill patients need understanding care. It is the little extra attention, such as an extra scoop of ice cream, the special shawl around the shoulders, the cigar available when desired, getting the patient up and back to bed before he is overly tired, that makes it necessary to have understanding nurses and attendants provide the nursing care at the annex.

The physical setup of the annex compares favorably with that of the hospital. There are utility rooms with modern equipment, conveniently located and provided with running water. Bathroom space is both ample and plentiful. Call lights at each bed, bedside tables, tray tables, plenty of wheel chairs, comfortable rockers and reclining lounge chairs which can be adjusted to comfortable positions all add





Left: The pillared porch is a lovely place to rest and read on a summer afternoon. Right: The old fireplaces have been converted into linen closets.

up to greater comfort for the patient. Three-crank metal beds which can be elevated to any desired position are provided. Ramps at exit doorways serve a dual purpose. In case of fire, patients in bed can easily be rolled to safety. Patients who are able to be out of bed can be rolled outdoors in wheel chairs.

Large sunny porches on both floors, overlooking spacious grounds, provide a delightful location for those patients who are up during the day.

When the annex was originally opened in June 1946, five patients were admitted. Today it is filled to capacity with forty-five men and women, indicating a greater potential demand for this type of service for chronically ill, elderly patients than was first thought. At the present time, the day staff consists of two graduate nurses, four nurse's aides and two orderlies. The afternoon and night shifts each have two trained attendants and two nurse's aides. Since the opening of the annex there have never been more than six patients at any one time who could entirely care for themselves. Approximately 50 per cent of the patients can help with their baths and to some extent help themselves while either in or out of bed.

Mealtime is a very busy time as more than 50 per cent of the patients must be fed and others must be helped. This is time-consuming and demands utmost patience on the part of personnel.

Visiting hours, afternoon and evening, are helpful in boosting morale. Very few patients have daily visitors, owing, we think, to the fact that they are hospitalized over such a long period of time. Five or six patients have visitors both afternoon and evening. Such visitors become acquainted with many of the other patients, which pleases them no end. Week ends are the busy times at visiting hours. Most of the patients who have only week-end visitors count the days from one week end until the next.

A few of the personnel live on the third floor of the annex as a convenience to the hospital in case they may be needed in an emergency.

All administrative work, including the admitting of patients, arranging for credit terms and accounting for patients' bills, is handled at the main hospital. The hospital's maintenance force reports to the annex from time to time as repairs are necessary. The superintendent, the director of nurses, maintenance supervisor and housekeeper make frequent visits and inspections to ensure proper functioning of all departments. If a patient becomes too acutely ill, or requires day-to-day services of the general hospital, he can be transferred to the main hospital by ambulance.

Recently instituted is our program of occupational therapy for these long stay patients. With the support of the women's auxiliary of the hospital and the Manchester Branch of the Hartford County Y.W.C.A., this project has started on a small but enthusiastic basis. Patients who are able to do productive work with their hands are employed in such occupations, which is helpful to them and to the hospital. Others who cannot do this, are entertained by moving pictures every week or so, while others have the use of radios contributed by the women's auxiliary. Arrangements are under way with the public library to provide books for the patients. After this program is fully developed, the next step will be the teaching of crafts, with an outlet provided by the organizations sponsoring the work.

From a medical standpoint, plans are under way for a program of physical therapy. When this is completed, a full program of occupational and physical therapy will enable a certain proportion of the chronically ill patients to be physically rehabilitated. A new venture for the hospital, it must be developed slowly to achieve the maximum benefits.

It is surprising how easily adaptable this spacious old homestead was to hospital needs with a minimum of expense and effort. The management of the Manchester Memorial Hospital is grateful to Cheney Brothers for placing this property at its disposal. The annex is serving a wonderful purpose in relieving crowded conditions at our local hospital. It affords many advantages from a medical and nursing standpoint for the elderly people of Manchester. This is especially true today with the expense and difficulty of constructing new hospitals.

Pioneering among small-town hospitals with the development of its annex for long stay elderly patients, Manchester Memorial Hospital is proving that American ingenuity can still devise ways and means of solving its present-day problems.

CLINIC FOR ALCOHOLICS

Makes Friends and Influences Patients

JOHN PARK LEE

Business Manager, C. Dudley Saul Clinic
St. Luke's and Children's Medical Center, Philadelphia

ALCOHOLISM, with some 750,000 victims in the acute stages, is rapidly becoming one of the nation's major public health problems. But American general hospitals are contributing virtually nothing to its solution. Without greater participation by the hospitals in the treatment of this disease, it is doubtful if any successful answer to the problem will ever be reached.

The medical profession generally and many hospital administrators recognize that alcoholism is a disease and that the alcoholic is a sick man. The difficulties which present themselves in providing care for the alcoholic. the heavy demand on existing hospital facilities, and the staggering financial burdens under which most hospitals labor combine to prevent an intelligent attack on the problem.

MAY RECEIVE GRANTS

The experience of the C. Dudley Saul Clinic at St. Luke's and Children's Medical Center, Philadelphia, is that operating income is adequate to cover normal operating expenses and provide good professional and nursing care. With the growing interest in alcoholism, hospitals can look forward to receipt of grants from state legislatures to cover costs which receipts from patients fail to meet.

The Saul Clinic, opened on June 10, 1946, with an eighteen-bed capacity, has received more than 1500 patients, has enabled many of these to launch a program of sobriety, has brought hope to thousands of wives, parents and children and has won for the hospital an immeasurable amount of good will in the community.

Certain fundamental principles seem to stand out in planning a hospital program for alcoholics:

1. Such clinics should be attached to general hospitals but should be physically separated, if possible, from the main hospital structure. The alcoholic thus has available to him, in addition to the clinic medical staff, all the diagnostic and therapeutic facilities of the general hospital and the attention of the specialists in all branches of medicine while being, at the same time, separated from the other hospital patients and surrounded only by other victims of the same disease.

2. Such clinics should have professional direction. In the Saul Clinic, the physician in charge is chief of the department of neuropsychiatry at St. Luke's and has associated with him on the staff two internists, two junior psychiatrists, a clinical pathologist, a psychiatric social worker, and consultants in internal medicine, pathology, psychiatry and sociology.

3. The nurses in such clinics also play a major rôle. The Saul Clinic has a male graduate nurse in charge of nursing and under him former army "medics" and navy "corpsmen" who are interested in medicine and hospital work and have adopted such work as their career, or who are working for college or advanced degrees in sciences allied to medicine or in medicine itself. They are trained in their technics by the physician and nurses of the staff before assuming their duties. Such men must receive good salaries and feel secure in their employment. At the Saul Clinic they are called "corpsmen," a title which commands respect and properly describes their duties.

4. Treatment should be limited to those who will voluntarily accept it. Any forced commitment will, of course, sober the patient but has little lasting value.

5. Such clinics should not be free. No alcoholic values what he receives gratis. One of the major steps in his recovery is assumption of financial responsibility. He should pay something for his medical care. The experience of the Saul Clinic is that the majority of its patients have been able and happy to pay for their care. Provision should be made for those whose difficulties have completely exhausted their financial resources or where payment would have to be met by the wife or parents out of meager earnings. Careful screening of such patients by the credit officers of the general hospital is an excellent method of weeding out the professional deadbeat or panhandler.

6. Payment should be on a blanket charge basis and in advance. The Saul Clinic charges $78 for a five-day stay, which includes room and board, nursing care, routine laboratory tests, routine drugs, an intravenous infusion, and professional services. The remuneration provided thus for the physicians is not part of general hospital receipts but is a direct fee for them.

7. Whatever system is worked out, there must be provision for the physicians. The work is difficult; it requires much time and frequently great strain. The physicians willing to work in this field will do so out of their interest in this problem and their concern for their patients, but they should receive fees for their services.

8. It is suggested that the clinic receipts be handled separately from those of the main hospital together with billings, records and other financial matters. In this manner a careful check can be maintained at all times on costs.

TWENTY-FIVE BED UNIT

The size of the clinic will depend on location and whether or not it is attached to a general hospital. The most efficient unit for a large city is one with a minimum of twenty-five beds making provision for both male and female alcoholics. The Saul Clinic takes only men and has been compelled so to limit its service simply for lack of available space. Plans, however, call for the provision as soon as possible of a smaller unit for women.

The therapy now followed at the Saul Clinic is outlined here as an indication to hospital administrators of what is required in the way of equipment and supplies.

Each patient receives upon admission a thorough medical examination with findings noted on the patient's chart. Daily observation is made of

each patient and another examination is given immediately prior to discharge. This is imperative. Alcoholism is a great mask and behind it often lie organic or other diseases which may be unknown to the patient and which will not be discovered if the patient is treated solely for alcoholism.

The whole man, not just the alcoholic, must be studied.

Routine laboratory tests are made for each patient: urinalysis, complete blood count, and blood sugar. Other tests as indicated may be made and unless the laboratory of the general hospital is able to give twenty-four-hour service, the clinic is advised to maintain its own laboratory.

The patient is given an intravenous infusion of 1000 cc. glucose in a saline solution with 10 units of insulin and an ampule of Sol B vitamin. Sedation is used sparingly and no patient is released until the effects of sedation have completely disappeared.

Fluids are urged upon the patient and he is placed on full diet as soon as possible. The intravenous infusion usually enables the patient to eat normally — often ravenously — within twelve to twenty-four hours after admission.

Each day a group therapy session is held in the lounge of the clinic attended by all patients able to be out of bed. The problem of alcoholism is discussed at these meetings which are led by the members of the staff, and at which questions are asked and answered freely. These meetings are an invaluable part of the five-day treatment as the alcoholic is thus given an understanding of his problem, a realization that he shares it with others, hope that recovery is possible, and renewed faith and beginnings of confidence in himself.

Each patient is interviewed by members of the staff prior to departure and enabled to obtain further insight into his problem. Through these individual interviews the moronic, or psychotic, or neurotic patient can be detected and proper guidance for his future care can be provided for his family.

Members of Alcoholics Anonymous visit the clinic regularly and patients are told of its effective work and urged to affiliate themselves with this group. Any hospital considering the opening of an alcoholic clinic should consult with the local A.A. group and obtain its cooperation in welcoming its patients upon their discharge.

The clinic also conducts an open forum weekly in the auditorium of the main hospital for the families and friends of the patients to bring to those with whom the alcoholic lives an understanding of the problem. The forum is considered by the staff a vital part in the therapy because understanding at home is vital for the recovery of the alcoholic.

A follow-up program is carried on by which continuous contact is maintained as far as possible with patients to enable the clinic to make some evaluation of its work and to assure the patients of the clinic's continued concern for their welfare.

Full details of the methods of the clinic will be furnished to all who inquire and the clinic welcomes visitors who wish to familiarize themselves with its technics.

After twenty months of experience, the staff of the clinic, the administrator and trustees of the hospital unite in the belief that this work is of major importance.

Alcoholics are desperately sick men. Yet they are usually competent and valuable individuals who can be rehabilitated and restored to their rightful positions in society.

Medicine is accepting its responsibility in this phase of public health to a great degree. The churches are becoming aware of the special nature of alcoholism and are changing their approach to the alcoholic. A lay organization, Alcoholics Anonymous, has salvaged some 50,000 men and women and expected to help 20,000 more during 1948.

It is time for the general hospitals to begin to make their contribution to the solution of this problem.

GOOD BLOOD FROM GOOD FRIENDS

RED tape means anxious hours when a desperately ill person needs "red blood." Because of a scarcity of blood donors, hospital blood banks seldom can meet the urgent demands for blood. A Milwaukee industrial plant, the Falk Corporation, is protecting its employes against serious delays when they are hospitalized and require transfusions. The Falk Life Saving Club was organized in 1945 to meet such emergencies.

During the war people answered the call of the Red Cross for blood donors to save the lives of our fighting men. When V-J Day came, civilian blood banks were low. A Falk employe, sinking rapidly in a Milwaukee hospital, needed immediate transfusions. The company sent out a call for blood donors among its employes. Thirty-one answered the call. After they were typed at the hospital, the stricken man received nine transfusions. He recovered with the help of his fellow employes who volunteered their blood.

This incident, plus the interest of the many war-time Falk blood donors, was the informal beginning of the Life Saving Club, one of the first in the country. Announcements of the new club went to employes with a request for volunteers. The response was encouraging. All those who answered had their blood typed at a near-by hospital. Headquarters for the club were set up in the plant hospital with the supervising nurse, Bernadine Springborn, in charge.

The Falk Life Saving Club functions simply. Interested employes contact the plant hospital. Miss Springborn makes arrangements for blood typing at a local hospital. Then a card specifying the particular type of blood is filed in the plant hospital. The new Life Saving Club member receives a laminated card of membership and an attractive club pin. Then his job is done until a fellow employe needs him.

When any one of Falk's 2200 employes needs a blood transfusion, the hospital calls the plant. The card file shows which employes are available with the right kind of blood. Three or four members are taken off the job immediately and sent to the aid of the suffering employe. The members receive full compensation for the time they are away from the plant. The date of the transfusion is recorded on the members' cards to ensure that one is not called before it is advisable for him to give blood again. — LORETTO FOX. *Falk Corporation, Milwaukee.*

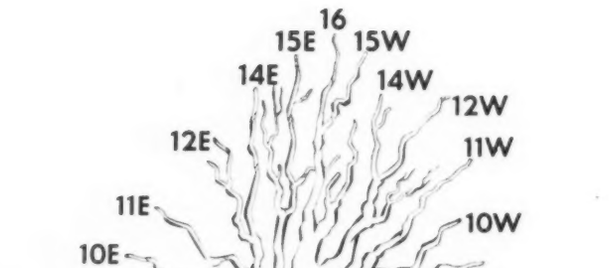


Figure 1: Wesley's "tree of service."

CENTRAL SUPPLY Is the Root of Good Service

CATHERINE A. BINDEL, R.N.
Supervisor, Central Supply
Wesley Memorial Hospital, Chicago

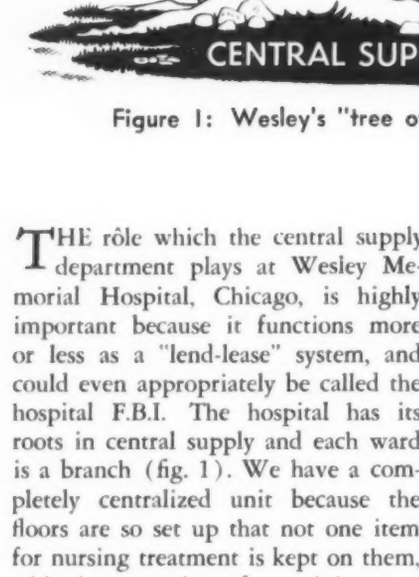
THE rôle which the central supply department plays at Wesley Memorial Hospital, Chicago, is highly important because it functions more or less as a "lend-lease" system, and could even appropriately be called the hospital F.B.I. The hospital has its roots in central supply and each ward is a branch (fig. 1). We have a completely centralized unit because the floors are so set up that not one item for nursing treatment is kept on them, with the exception of a recipient set, emergency fluids, a 10 cc. and a 2 cc. syringe.

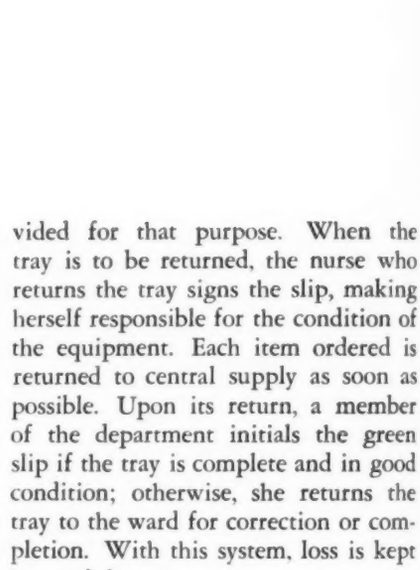
In studying the function of this department it is best to begin on the wards. The head nurses are instructed to order the day's supplies, anticipating as much as is possible their needs for the day. This, however, does not mean that "Stat" orders are not filled, for orders come in at any time of day or night, and they total about 650 in a twenty-four hour period.

Suppose a doctor wishes to do a "chest tap." A floor nurse writes the order for a chest tray on duplicate copies of green and white requisition slips, giving the patient's name and room number, and signs her own name. These requisitions are dispatched via pneumatic tubes to central supply where they are received in five seconds. The nurse who receives the order takes a chest tray from the shelf, adds an ampule of novocaine, and places it on the dumbwaiter along with the time-stamped green slip for identification.

The white copy remains on file in central supply until the tray is returned. Under normal conditions this entire procedure takes about five minutes. On the ward when the tray is removed from the dumbwaiter, the green slip is placed in a file box provided for that purpose. When the tray is to be returned, the nurse who returns the tray signs the slip, making herself responsible for the condition of the equipment. Each item ordered is returned to central supply as soon as possible. Upon its return, a member of the department initials the green slip if the tray is complete and in good condition; otherwise, she returns the tray to the ward for correction or completion. With this system, loss is kept at a minimum.

The department occupies two large rooms in the basement; one is a workroom containing an ample number of wood work tables, and the other, a dispensing room which is lined with





Left: Figure 2. Card index contains directions for assembling tray. Right: Figure 3. The home-made bottle drainer consists of a metal rack with two rings, each of which holds an inverted gallon bottle.

shelves and has a number of stainless steel counters containing cabinets and drawers for sterile supplies. Returned equipment is collected at the dumbwaiters and is checked in by personnel on the dispensing assignment. At regular intervals throughout the day, sterilizing room personnel transports this equipment to the workroom where it is washed, assembled and prepared for autoclaving.

All equipment is processed and assembled according to precise directions which are typewritten on a card index file (fig. 2). This file also contains a pencil sketch of each tray as well as directions for assembling it. It carries instructions for various procedures, such as needles, catheters, tubes, wrapping and autoclaving, thus making it possible for us to maintain absolute uniformity and standardization. A copy of the file is also kept in the dispensing room to aid those who check in equipment. It has proved to be a valuable teaching asset and serves as a constant guide for new personnel.

It is essential that all procedures run on schedule. For instance, if the preparation of needles is not begun by 7 a.m. they cannot be completed in an eight-hour shift. Genito-urinary tubing and bottles, catheters and gastric tubes are cleaned and processed once every twenty-four hours. The task of bottle washing is facilitated by our homemade bottle drainer which is a point of pride and a definite timesaver. It is a metal rack composed of two rings each of which holds an inverted gallon bottle while it is being drained (fig. 3). Delivery room and nursery linen is also a morning task. A multiple head faucet on one sink greatly facilitates tubing and needle procedures.

Needles are one of our biggest problems, for we clean an average of 1500 daily and it is our most time-consuming procedure. The needles are collected in a basin of green soap solution from 7 a.m. to 7 a.m. Then the soap solution is removed and they are thoroughly rinsed with hot tap water, after which they are covered with distilled water. Each hub is cleaned with an applicator and all bloody needles are set aside for styletting. They are then placed on a needle washer (fig. 4), attached to a pressure jet and flushed with tap water.

Any needle through which water will not run is removed and styletting is repeated, after which the needle is again attached to the pressure jet and flushed for at least two minutes. The needle washer is then connected to distilled water which constitutes the final rinsing. Excess water is blown out by air pressure; then needles are sorted and placed in constrictor tubes for sterilization. One hour each day is devoted to sharpening needles, which we do on an electric needle sharpener.

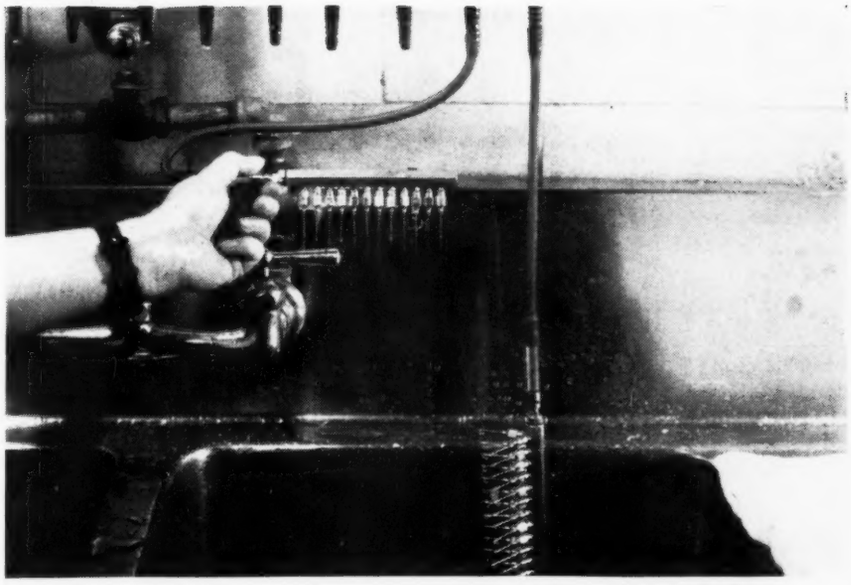


Figure 4: Needles are placed on a washer attached to a pressure jet.

Syringe cleaning and assembling is a continuous process. The total number washed daily averages about 1200. They are disassembled at the dumbwaiters, collected in perforated basins, then submerged in a sink containing fatty alcohol sulfate solution, each syringe being cleaned separately with an applicator and brush. They are then submerged in very hot tap water after which they receive a final rinse with distilled water.

Finally, they are assembled and all but the 2 cc. syringes are wrapped in a double muslin wrapper. The 2 cc. syringes, with a needle attached, are placed in a sterile metal tube and covered with a rubber cap, collected in wire baskets and autoclaved (fig. 5). Studies have demonstrated that these sterile tubes can be used much more economically than can any kind of wrapper and our laboratory culture tests have proved that autoclaving the syringe in this tube with the cap already attached is effective. Moisture factor is, of course, retained by inserting the plunger into the barrel while it is still wet.

Here at Wesley, all syringes are autoclaved, thus eliminating the danger of breakage which so often results from forceps handling. Tip breakage is eliminated by using all Luer-Lok syringes. Through studies we have been able to demonstrate that breakage

Figure 5: 2 cc. syringes with needle attached are placed in a sterile tube.

has been kept as low as 1½ per cent on 2 cc. syringes and about 1 per cent or less on all other sizes.

By keeping careful records, we have been able to analyze costs and review procedures, thereby making our department a testing and proving ground for new ideas. Following are a few items on which studies were made and in all cases a routine was changed because the newer method was proved to be either more efficient, safer or more economical.

1. We use commercially prepared ampules of novocaine rather than bulk.
2. We use a quaternary ammonium salt in most instances where alcohol was formerly used.
3. We no longer mend rubber gloves.
4. We use commercially prepared intravenous and recipient sets.
5. We use ready-made dressings, sponges and applicators.
6. We use Luer-Lok syringes and metal sterile tubes.

Inasmuch as central supply is no longer in the infancy stage, it hardly seems necessary to enumerate its advantages, but they can be briefly summarized:

1. All sterilizing is done according to rigidly correct standards.
2. Standardization of procedures and uniformity of trays can be established and maintained.
3. Less equipment is needed.
4. Better care is taken of equipment; responsibility is shouldered by only one department.
5. There are less breakage and loss.
6. Much time is saved.

MEDICINE MAKES NEWS

The hospital's job is not to keep scientific news out of the press but to see that such news is presented accurately in order to serve the best interests of the hospital, the doctors and the public

ARTHUR J. SNIDER
Science Editor, Chicago Daily News

THE stirring laboratory victories over pain and disease are spreading news of medical science over the front pages of the nation's press. Editors are reporting an all-time high in reader interest. The public is eager to learn of wonder drugs, treatments for cancer, and new surgical technics. Recently at Columbia University, newspapermen from across the nation gathered in a week-long seminar to evaluate fields of news—crime, political, labor, foreign, Washington, scientific, agricultural, business and sports. Their conclusion on medical news was this: "Medicine is the only news with a 100 per cent reader potential." In other words, the medical story in the newspaper has the best chance of attracting and holding the attention of every man, woman and child who picks up the paper that day.

Concurrent with this reader upsurge is the emergence of the hospital in the changing pattern of postwar medicine as a focal point of fundamental research. More and more intellectual stalwarts are turning from the allure of private practice to try their skills on the frontiers of the unknown. The spirit of scientific inquiry is at a new peak. On planning boards everywhere, hospitals are mapping great research buildings to whip microscopic enemies.

The two developments, while coincidental, are of mutual significance. Newspapers now can look to hospitals as a fountainhead of medical information. Hospitals can take advantage of a whetted public interest in medical news to further their public relations programs.

In addition, both groups must now work together to fulfill an obligation to the public, namely, to present the purposes, methods and results of scientific medicine in such a way that this magnificent adventure of the human mind can be understood by all the people. It is important that they understand, not only that they may protect themselves from the cultist, the pseudoscientist and others who prey upon the public for selfish interest, but also that man may be freed of fear and superstition. There are still too many people who look upon science as a strange and mysterious black magic.

But before attempting to weld a happy partnership, it is probably wise at the outset to clear the atmosphere with a frank confession of difficulties on both sides and to examine some of the reasons behind them.

The newspaper's complaint is the dearth of information of a public nature emanating from hospitals. The hospital takes the stand that the release of such information lies with the staff doctor. The doctor readily admits his reticence. But he explains it results from failure of the newspaper to handle the material properly. His common complaint is distortion and undue emphasis. If the story should happen to deal with the experimental use of a new drug, as in the case of Babe Ruth, for example, the doctor and hospital are flooded with requests even though validity of the treatment is yet to be established. This not only distracts from the doctor's work but also causes great anguish to denied relatives who believe their loved ones could be helped.

The majority of newspapers will have to plead guilty to that indictment. But perhaps judgment can be softened by pointing out there is an awareness of the problem and an attempt to correct it. A hopeful development is the addition to news-

paper staffs in recent years of men specializing in the presentation of scientific news. Usually these are qualified newsmen formerly in other fields of the profession who evinced an interest in and an appreciation for scientific developments.

Today the major newspapers of the country have science writers. More and more of the smaller ones are assigning men to devote more and more of their time to this type of work. There exists today a National Association of Science Writers whose code is as rigid as that of the medical profession.

These men and women are as anxious to present accurate and reliable information as the scientist is to have them. They feel that sensationalism is not only alien to science but also unnecessary, for few subjects are more interesting to the healthy human mind than drama and discovery. They contend the scientist is entitled to expect that a newspaper will convey the meaning and spirit of his work with proper perspective, respect, dignity, and without unfair implications. They believe that, insofar as possible, the newspaper should go along with the medical man when he believes a story is not yet ripe for presentation.

Another complaint by the doctor is that the newspaper publishes his name in the story and he then becomes guilty of violating the medical code of ethics.

Newspapers take the view, however, that a doctor's name lends authenticity to the story and serves to educate and safeguard the public against the quack and the unscrupulous writer.

In this we are supported by a number of leading medical men who believe that the rigid code of medical ethics with respect to publicity is of more harm than benefit to the profession. A spokesman for this group is Dr. A. C. Ivy, vice president of the University of Illinois in charge of medical, dental and pharmacy colleges. He says:

"The traditional reticence of the medical scientist is responsible for widespread public misunderstanding. I understand and appreciate the reasoning which was responsible for the ethical ban on publicity by medical practitioners, but I believe it has been carried to ridiculous lengths in its application to research scientists. It is like agreeing that if it is good to trim our fingernails, it would be even better to trim them to the knuckle.

"It is absolutely essential that proper means be made to convey to the public authentic information on medical developments. If we scientists do not make positive provisions for public understanding, we must accept the fact that others who have less knowledge and lower standards will lead public thought.

"The traditional reticence of scientists, I think, can be opposed on the following grounds. Science by definition deals with discovery and classification of verifiable knowledge. A scientist, therefore, is a discoverer and a collector of knowledge. The social function of the scientist is not only to discover and collect knowledge, but also, what is equally important, to disseminate knowledge.

"It is not to the best interests of the educational process to confine this dissemination to the classroom or laboratory. Unfortunately, too many scientists do not fully understand this function and duty. Too many are content to exchange information among themselves while keeping themselves aloof from the public."

It is the hope of newspapers that hospitals will set up some plan for disseminating their scientific information. Perhaps a panel of staff doctors from the various specialties, working with the public relations department, could decide upon suitable material.

The job facing hospitals, it would appear, is not how to keep stories out of the paper but rather to see that stories are presented in a way that makes sense and conforms to reasonable standards of accuracy. Hospitals will not correct the tendency toward sensationalism by remaining aloof from the reporter. Material prepared with the active cooperation of the hospital pays dividends to the hospital, the newspaper—and the public.

WAITING FOR OPERATION

The following question-and-answer appeared in the British Medical Journal, Nov. 22, 1947.

QUESTION: A.B. is referred by his medical attendant to a particular consultant at a hospital. A diagnosis of early carcinoma of the stomach is made and confirmed. The patient is advised to have an operation, to which he agrees, and he is put on the waiting list for admission. Presumably the consultant has entered into a contract with the patient and his doctor to carry out the treatment. The patient is not admitted for six or even twelve months, and the growth becomes inoperable.

Is this the responsibility of the consultant or the committee of management of the hospital? Should the law decree that the onus is on the committee of management; is it not incumbent upon the committee to review the number of patients on the waiting list and to advertise or otherwise make known to all concerned what prospects it envisages of fulfilling the contracts to which it is a party?—HAMILTON BAILEY.

ANSWER: Our Legal Correspondent writes: Any cause of action must be founded either on contract (agreement between the parties) or on tort (civil wrong; in this case failure to use proper care). In each case the burden of proof is upon the patient. To succeed in an action for breach of contract he must show that an agreement, express or implied, existed to admit him to hospital or to operate on him, or both, while the growth was still operable. If he contracted for operation with the consultant, or for admission with the hospital, on this understanding and could prove it, he might have a chance of success.

It is, however, hardly conceivable that either a consultant or a hospital would undertake such an obligation in these days of shortage of beds and would fail to tell the patient that he must wait his turn. Neither the consultant nor the hospital is required to do the impossible. If the patient seeks to found his action in tort, he must prove that the consultant or the hospital, or both, failed to use reasonable care. He might succeed if he could show that it would have been reasonable to warn him of probable delay and that he had not been warned, or that he had been wrongly deprived of his turn in the list, or if there was some other circumstance indicating negligence. Otherwise, he would have no chance of success at law.—ED., B.M.J.

PEOPLE IN PICTURES

Apprenticeship training in nursing is gained by these Scottish girls at the prenursing school, Seymour Lodge, Dundee, Scotland. The course is from one to three years, according to the student's age and academic qualifications and fills the gap in her training before her normal probationship.

Above: Dr. Robert L. Novy, president of Michigan Medical Service, receives plaque awarded to first Blue Shield plan to enroll 1,000,000 members. Left to right are: Dr. Paul R. Hawley, chief executive of Blue Cross-Blue Shield commissions, Dr. Novy, Dr. L. Howard Shriver of Cincinnati, president of Associated Medical Care Plans, Inc., and Jay C. Ketchum, the executive vice president of the plan.

Right: Final details of the new formula whereby Associated Hospital Service of New York will pay its 260 member hospitals at least $2,500,000 during the next year are discussed by Louis H. Pink, president, with Associated Hospital Service and United Medical Service officers and members of the staff.

The first group of graduate nurses to take the nine-month advanced clinical course in operating room technic and management offered by St. Mary's School of Nursing, Rochester, Minn. On completion of the course the students received a certificate and were granted ten points of college credit at the College of Saint Teresa at Winona, Minn.

Below: Presidents, past, present and future, of the Maryland-District of Columbia Hospital Association gather at the annual meeting. They are: James Capposella of Emergency Hospital, Washington, D.C., (out-going), Benjamin Wright, Memorial Hospital, Cumberland, Md., (in-coming), and Leo G. Schmelzer, George Washington University Hospital, Washington, D.C., who was named president-elect.

An Insurance Man Has to Think of Everything

ROBERT MAXWELL

Arkansas Association
of Insurance Agents
Texarkana, Ark.

THE subject of an insurance program for hospitals naturally divides itself into two parts. In the first place we should consider the insurance program to cover the property owned by the hospital. The other phase of the subject is providing proper insurance coverage for what we call "third party claims." This means claims arising out of injuries to employes or to members of the public, or to patients under treatment. We shall deal first with the insurance on property owned by the hospital.

EXTENDED COVERAGE VALUABLE

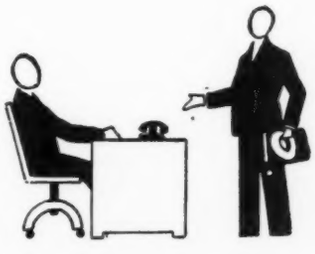
I am sure that most, if not all, hospitals carry fire insurance on their buildings and contents. It is customary to carry insurance against the hazards of fire and extended coverage. The extended coverage hazards are tornado, hail, explosion, riot, civil commotion, falling aircraft and vehicle damage. It is possible to endorse the policy to cover also the additional hazards of malicious mischief and vandalism. The cost is reasonable, and I suggest you consider including it in your insurance program. The most important step in an insurance program insofar as covering property owned by the hospital is concerned is to be sure that an adequate amount of insurance is being carried. Here are three steps to follow in determining that amount.

1. Find out first what it would cost to put the building back exactly as it is, but completely new. Building costs have changed so much that a building put up even five years ago may be inadequately insured today. Usually, you can arrange with a local contractor to give you this figure, either without cost or at a nominal cost.

2. Determine the percentage of depreciation of the building depending upon its state of repair and taking into consideration things that have to be replaced about the building, such as roof, repainting, interior decorating, and the general condition of the building. Your contractor can be of help in arriving at this figure. If, for example, the percentage of depreciation is estimated at 25 per cent, deduct that from the cost of replacing the building new.

3. Deduct from the figure the cost of uninsurable items. This would be the cost of excavation, cost of foundations below the level of the ground, cost of underground piping, cost of laying sidewalks, and items that are not normally insured. After deducting this figure you have then the gross insurable value. It is generally recognized that the probability of having a total loss in which there is no recovery from salvage is extremely remote. Most businessmen, therefore, buy insurance to either 80 or 90 per cent of the gross insurable values depending upon their individual desires. This, then, is the amount of insurance that should be carried on the building. The same procedure should be carried out on equipment, furniture and fixtures and supplies, and that figure will give you the amount of insurance which should be carried on each item.

At this point I would like to say a word about the co-insurance clause.



Probably most hospitals have co-insurance clauses in their insurance policies. There has always seemed to be some degree of mystery about the co-insurance clause, but there should be no reason for any mystery about it. It is put into an insurance policy because the rate is lower when the clause is included. The principle back of it is no different from buying any commodity on which you get a lower rate for a larger purchase.

The co-insurance clause simply provides that in return for a reduced cost the policyholder agrees to carry 80 or 90 per cent (as the case may be) of insurance to value, and failing to do so becomes a co-insuror. If you have a co-insurance clause in your policy let me just say this: Either comply with it, or have your agent take the clause out of the policy. The reason is that you are penalized on any loss that may happen, regardless of size, if you do not comply with the co-insurance clause.

INSPECTION WORTH THE PRICE

If the boilers are located in the hospital building, you should include boiler insurance in your program. The regular fire and extended coverage policy excludes coverage for claims arising out of the explosion of a steam boiler. Boiler insurance should be carried as a matter of public safety. The insurance companies usually inspect the boilers twice each year, and their primary concern is to see that an accident does not occur. Therefore, the insurance should be worth its cost, simply as an accident prevention measure without regard to the actual insurance protection offered in connection with it.

If you own radium, insurance can be purchased on an all-risk basis to take care of its loss. This is available on several forms and your agent can advise you on the form which will best suit your individual needs and requirements.

Condensed from a paper presented at the Arkansas Hospital Association meeting, 1948.

Most hospitals handle money. There is now available insurance that will take care of any loss of money, either inside the premises or while it is being conveyed to the bank, which will include not only robbery or burglary, but also mysterious disappearance. In other words, if you simply check up some morning and find that $100 is missing out of the cash drawer that loss is covered. The rates will vary according to the individual location, and the type of safe protection you have for the money. That is known as "All Risk Money and Securities Policy" and represents the last word in protection to money and securities.

There are many other forms of insurance which some individual hospitals may require, such as fidelity bonds on employes, business interruption insurance, which incidentally pays continuing expenses and profits in the event the hospital is destroyed by fire.

CLAIMS FOR INJURY

We have covered the principal hazards involved in the ownership of property and damage to it. Now, I would like to discuss proper coverage for claims arising out of the operation of a hospital and involving injury to employes or members of the public.

Immunity of charitable organizations from suit for bodily injuries has been breaking down rapidly all over the country as one court after another examines the ground on which it rests. In some states full immunity has been granted on all cases up to the present time, but who can tell when this trend may be broken?

Here are some of the questions that the hospital should ask itself. Are we liable to beneficiaries, *i.e.* those persons who receive our services without costs? Are we liable to those who receive our services but pay for them? Are we liable to members of the public who might be injured on our premises? Are we liable for negligent acts or omissions of employes or servants? Are we liable for negligence in selecting employes and servants?

In the forty-eight states of the Union, we find varying degrees of liability on charitable institutions, and we do not believe that any lawyer can safely say today that any hospital can stand on the immunity granted under the statutes of its state and feel perfectly free of any and all liability to employes and members of the public. A charitable institution can buy insurance and yet be certain that the insurance company will not try to take advantage of the immunity granted by law by having attached to all of the policies an endorsement providing that the immunity will not be used in defense of any claim except with the prior written permission of the insured. With this endorsement, claims are handled in exactly the same manner as they would be by an institution operated for profit.

One of the primary coverages that every hospital should consider is insurance against claims arising out of accidents to employes. The Workmen's Compensation law in Arkansas, for example, provides that the employer shall pay the medical bills and certain stipulated sums for injuries and occupational disease arising out of or in the course of employment. It is my opinion, therefore, that hospital employes who contract communicable diseases in the course of their employment would be compensable under the present act.

I have made some search into the records and find that there have not been any cases before the Workmen's Compensation Commission that have been disputed on this point. The Arkansas law is a very broad one. The Workmen's Compensation carriers have paid such claims without attempting to raise any question as to their validity. The cost of this insurance is modest, the current rates being 30 cents per $100 of pay roll for professional and clerical office employes and 73 cents per $100 of pay roll for all other employes, which means that if the hospital has an annual pay roll of $10,000 and no professional or clerical employes, the current cost would only be $73 per year.

Under Workmen's Compensation law, the benefits include full medical expense or virtually that, plus payment to the employes for time lost in accordance with the law. It is possible for a hospital to buy insurance and exclude coverage on the medical benefits if it elects to do so. This is a choice which most businesses do not have an opportunity to make, but in view of the fact that the average hospital has medical benefits already available, it is possible to buy coverage that excludes them.

Again, I want to raise the point of the charitable institution. The Workmen's Compensation law in one state excludes charitable institutions from its provisions; however, they may come under the law if they elect to do so. Some lawyers feel that there is question as to whether all hospitals in this state would be given the benefit of the charitable institution clause in the act. It might be necessary for the individual hospitals to prove conclusively that their funds were not diverted to any other cause whatsoever in order to establish their position as charitable institutions and be entitled to the protection of this particular clause in the Workmen's Compensation Act.

So much for your liability for injury to employes. I would like now to mention the possibility of your having liability for the operation of automobiles. Of course, if you own automobiles you should have public liability and property damage insurance on such cars, but there is another hazard which I would particularly like to call to your attention because it is possible that most hospitals do not have insurance protection against it. That is the operation by employes of automobiles that are not owned by the hospital. If you send an employe to the grocery store for supplies, or to the wholesale druggist, from the moment that employe gets into the automobile and starts on the journey until he returns, as long as he is on business for the hospital you have liability for the operation of that car just as surely as if you owned it. There are many such cases on record, and so the insurance companies have made available what is known as "Non-Ownership Liability Insurance" at rates which are very reasonable to take care of that liability. Such insurance is an essential part of a sound program.

LIABLE FOR ITSELF

It is possible for an institution to have liability for the very existence of the hospital itself. This is known as "General Public Liability Insurance" or sometimes as "Owners, Landlords and Tenants." It takes care of liability for accidents arising on the premises out of slippery floors or things of that sort. The cost is not too great and this coverage should be a part of the insurance program for every hospital.

We now come to a consideration of coverage which I consider essential, and that is liability for claims arising out of malpractice, error or mistake.

Professional liability insurance shields the hospital from one of the most troublesome losses of all: actual, exaggerated or fictitious claims for injuries arising while patrons are receiving care. The modern hospital is sufficiently public minded to want to make fair redress irrespective of technical legal aspects. In fact, this is the only sound approach even from the strictly legal point of view inasmuch as the cloak of charitable immunity is fast slipping away, even in those jurisdictions where it is at present in force.

Even in cases where no judgment is obtained the cost of defense is often expensive. We had a case in our own office a number of years ago of a heavy lawsuit against a hospital for malpractice, a suit which we were fortunate enough to win. Yet when we received the bills from the lawyers, from the experts who testified, and the court costs we found that the total was $3600 on a case on which no judgment had been obtained.

PROBABILITY OF LOSS

In malpractice insurance we again encounter the problem of whether the charitable institution should purchase coverage or not. It is customary for the insurance companies to charge a lower rate to the hospital that is a charitable institution, so in our opinion, the problem is one of *probability* rather than *possibility* of loss, and professional liability insurance is one of the essential coverages to be carried. It is customary for malpractice liability policies to carry a provision that the company will not compromise or settle any claim without the prior written consent of the insured. This provision is intended to protect the integrity and professional standing of the institution and is not as a general rule contained in a public liability policy.

Up to this point, we have discussed the insurance program that should be carried out by the hospital. I would like now to discuss the type of carrier in which you should place the insurance. In general, insurance is written by three types of insurance carriers: mutual companies, reciprocal and Lloyds, and capital stock insurance companies.

It is important to select an insurance carrier with financial strength and ability to pay any losses that may occur. Approximately 85 per cent of all the insurance written in the United States today is written by capital stock insurance companies in the fire and casualty insurance field. For safety and security, therefore, it would be our recommendation that your insurance be placed in such companies. When you buy insurance from a capital stock company, you obtain the services of a local capital stock insurance agent and therefore receive the benefits of the help, advice and counsel not only of the insurance company itself, but also of a capable locally trained and educated insurance agent.

Next, we come to the selection of the agency with which to place the business. Many hospitals feel that it is necessary that they divide their business among several organizations. If that is the case you should first select the agent in your town whom you consider to be the most competent to advise you as to the insurance program you should follow. Call him in, talk frankly with him about your insurance program, and tell him from the outset that you are not going to be able to give him all the business, but that you expect him to be responsible for your program, that you expect him to recommend the coverage and the limits which you should carry, and that then it is going to be necessary that you place a certain amount of business with other agents. Give him the names of the other agents and the amounts, percentage-wise, that you expect them to receive, and I think in most instances you will find the agent perfectly willing to service your account on that basis.

The insurance business is rather complex and it is necessary that the program be tailored to fit the needs of the individual hospital. No one can provide a real insurance program which will meet these requirements if he is cutting the cloth in the dark. You need to have one agent supervising the entire account, checking the coverage, being sure that the policies are concurrent, and seeing to it that you are getting the best possible buy for your money.

VOLUNTEER ACTIVITIES

"Out of the Mouths of Babes"

Have you read about the original Teen Ager Hospital Auxiliary in Westwood, N.J.? The teen age group there resented the publicity given juvenile delinquents and decided they wanted to get some press notices for constructive activity. And what press notices they are getting!

There are some ideas in the Teen Age auxiliary for women's volunteer groups. No. 1 idea is: Why don't you join the Pascack Valley, New Jersey, movement and interest the young people in your high schools in promoting their local hospitals? You can get the necessary information by writing President Franklin Webber, Teen Ager Hospital Auxiliary, Westwood, or its trustee supervisor, Mrs. G. Robert Bohlin, 122 Lexington Avenue, Westwood.

Another idea, if you have not tried it, is the Teen Agers' latest money raising project. They are showing the public a model home in a real estate development in Hillsdale, N.J. The builder allows them to collect a 10 cent admission fee from all visitors. In the first three weeks the youngsters took in $250, and they are still operating.

The model home is open from 2 to 6 p.m. on school days and from 12 noon to 8 p.m. on Saturdays and Sundays. The Teen Agers keep two persons on duty throughout those periods.

Like many women's auxiliaries the Teen Agers are publicity agents for the hospital. In addition to their many money making ventures they are giving free concerts in various communities in the area of their proposed hospital. The mayor speaks briefly, as does a local physician, and the president of the hospital association puts in a three-minute plug for the hospital project. The concerts are widely attended and make many friends for the new venture.

Best of all, there are no juvenile delinquents in the Teen Age auxiliary, nor are there adult delinquents among women's auxiliaries. Perhaps one cure for erring youngsters or for erring wives and mothers would be to give them heavy jobs on a hospital auxiliary.

ABOUT PEOPLE

Administrators


Dr. Joe R. Clemmons

Dr. Joe R. Clemmons, executive vice president and medical director of Roosevelt Hospital, New York City, announces his retirement January 1. Dr. Clemmons has been active in hospital affairs in New York since joining Roosevelt Hospital in 1937. He was formerly associated with Strong Memorial Hospital, Rochester, N.Y. Dr. Clemmons is a fellow of the American College of Hospital Administrators.

Dr. Madison B. Brown, formerly assistant medical director at Johns Hopkins, has been appointed director of Roosevelt Hospital to succeed Dr. Clemmons. Dr. Brown was formerly identified with Roosevelt Hospital as assistant director, having joined that institution in 1940. Following five years of war service, in which he attained the rank of lieutenant colonel, he returned to the same post until 1947, when he assumed his duties at Johns Hopkins.

Grace B. Hinckley has retired as superintendent of the Methodist Hospital, Brooklyn, N.Y., after a service of thirty-five years. Miss Hinckley joined the institution in 1913 as superintendent of the school of nursing, later becoming assistant superintendent of the hospital. In 1929 she was made superintendent.

Mabel R. Duryea has retired as director of the obstetrical division, Methodist Hospital, Brooklyn, N.Y., following thirty-two years of service with that institution. A graduate of the hospital, Miss Duryea became night supervisor and in 1924 was advanced to the post which she held continuously until her retirement.

Dr. August Groeschel has been appointed assistant medical director of New York Hospital. Formerly assistant director of the Health Insurance Plan, New York City, Dr. Groeschel was graduated from the hospital administration course at Columbia University in June 1947.

Dr. Stephen S. Brown has resigned as director of Maine General Hospital, Portland, because of ill health. Dr. Brown is, in point of service, the oldest hospital administrator in Maine, having assumed the post in 1930. He was one of the founders of the Maine Hospital Association and three times its president. He is also a former president of the New England Hospital Assembly.

John A. Lindner has resigned as administrator of Laconia Hospital, Laconia, N.H.

Carroll J. Dickson is the newly elected president of Long Island College Hospital, Brooklyn, N.Y., succeeding Assistant Secretary of the Army **Tracy S. Voorhees,** who resigned October 1. **Cyril J. Redmond,** who was elected to the board of regents in 1946 and who has been serving as vice president of the hospital since June, has been named executive vice president.


H. C. Allnutt

H. C. Allnutt has been appointed superintendent of Sherbrooke Hospital, Sherbrooke, Que. In the hospital field since 1935, at which time he became associated with the Montreal General Hospital, he left that institution in 1943 to become superintendent of the Herbert Reddy Memorial Hospital in Montreal.

Olin L. Evans has resigned as superintendent of Osteopathic Hospital, Philadelphia. Prior to joining that institution three years ago, Mr. Evans was associated with the Community General Hospital in Reading, Pa., for nine years.

Sister Andrea, immediate past president of the Indiana Hospital Association, is now the administrator of De-Paul Hospital, St. Louis. Transferred from St. Vincent's Hospital, Indianapolis, she has been succeeded there by **Sister Lydia Hoffman** of St. Thomas Hospital, Nashville, Tenn.

Sister Emile, administrator of St. Mary's Hospital, Evansville, Ind., for four years, has been transferred to Charity Hospital, Lafayette, La. She has been succeeded at St. Mary's by **Sister Justina Morgan,** former administrator of St. Joseph's Hospital, Alton, Ill.

Dr. Francis J. Bean has been appointed superintendent and county physician, Pima County General Hospital, Tucson, Ariz. Dr. Bean was formerly superintendent, Henry W. Putnam Memorial Hospital, Bennington, Vt.

Armour H. Evans is now the acting superintendent of Wesley Hospital, Wichita, Kan., succeeding **H. L. Gleckler.**

Harold L. Hutchins Jr. has been appointed assistant director of Aultman Hospital, Canton, Ohio. Mr. Hutchins was awarded the degree of master of hospital administration from Washington University, St. Louis, last June and completed his administrative internship at Grasslands Hospital, Valhalla, N.Y.

Mary Shannon Webster, formerly administrator of Waynesboro Community Hospital, Waynesboro, Va., took over her duties as superintendent of Connellsville State Hospital, Connellsville, Pa., November 1.

John H. Blake is the new administrator of Wabash County Hospital, Wabash, Ind. Mr. Blake was formerly administrative assistant of the Women and Children's Hospital, Chicago.

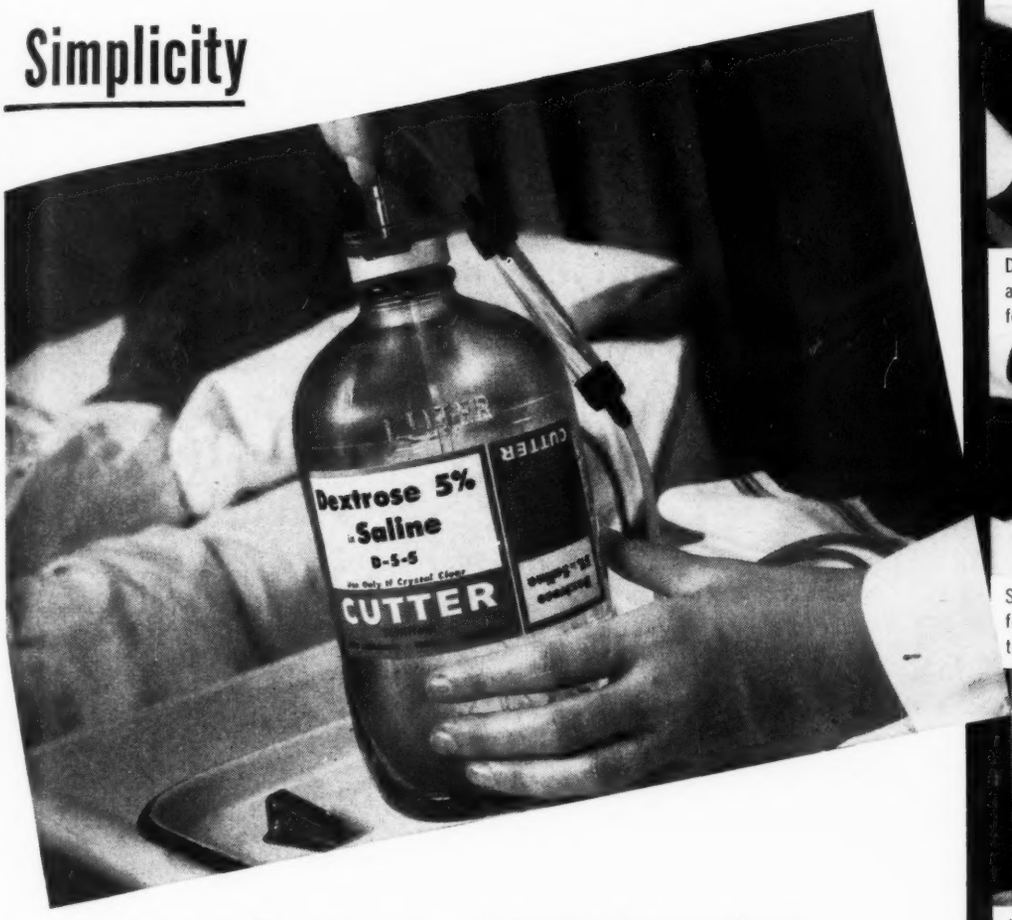
John M. Wilcoxon has been appointed to the newly created post of business administrator of Starling-Loving University Hospital, Columbus, Ohio. Previous to his appointment, which became effective November 15, Mr. Wilcoxon was Ohio superintendent of the budget.


Frank B. Adair

Frank B. Adair, assistant executive director of Sydenham Hospital, New York City, has accepted the appointment of administrator of Community Hospital, Wilmington, N.C. Mr. Adair came to Sydenham three

(*Continued on Page* 170.)

Simplicity



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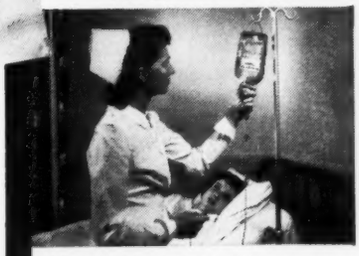
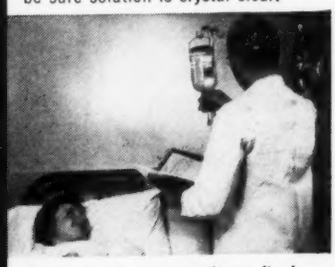
Disposable intravenous set, already assembled and sterilized, saves time for nurses and other technicians.

Scored metal foil is easily stripped from neck of Saftiflask by pulling on tab. No prying, no broken fingernails.



When placing solution flask on stand, nurse makes final check to be sure solution is crystal clear.



Attending physician makes a final examination, to be certain solution checks with his written orders.

These photographs are from a newly-completed strip film, prepared for use in hospital training programs. For a print, write to Cutter Laboratories, Berkeley 1, California.

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ONE of the areas in which hospitals and institutions have not fully realized their potential in terms of financial support is that of properly educating prospective donors as to the tax savings allowable as the result of gifts to a nonprofit institution. In order properly to educate prospective donors, a complete program of interpretation of tax savings was developed by the officers of our institution. Fred A. Eppenberger of the law firm of Salkey and Jones, St. Louis, counsel for the Principia Corporation, cooperated in the preparation of this article and reviewed the tax data contained herein.

Federal and state governments have, for many years, seen fit to encourage the establishment and furtherance of charitable, religious and educational institutions by granting tax advantages to such institutions and to their benefactors. Thus, under the internal revenue code, a nonprofit eleemosynary institution is exempted from income taxes.

Gifts to a qualified hospital may be deducted by the donor from his net income for income tax purposes and are wholly exempt from gift and estate taxes. There are several ways in which an individual may make gifts to a hospital during his lifetime. They are chiefly gifts of money from income or capital and gifts of property, such as stocks, bonds or real estate.

The following paragraphs suggest tax savings and economies that your attorney can take advantage of in helping a donor to plan such gifts.

INDIVIDUAL INCOME TAXES

The federal statutes permit an individual to deduct his benefactions from his net taxable income up to a limit of 15 per cent of his adjusted gross income in any one year. This makes possible a considerable reduction in federal income taxes for a taxpayer making a gift to a qualified institution.

For example, an unmarried person with a net taxable income of $100,000 in 1948 who makes no charitable contributions would have a federal income tax of $59,221.60, leaving him a residue of $40,778.40 after taxes. If this person makes a gift to an eligible institution of $15,000 in 1948, the additional deduction would reduce his income tax $11,352 to a net tax of $47,869.60 and leave him a residue of $37,130.40 after both the contribution and the income taxes, or only $3648 less than if he had not made the gift. Thus, such a person's gift of $15,000 to a college would cost only $3648. Most states that levy income taxes have similar provisions, so the cost to the taxpayer will usually be further reduced by savings in state income taxes.

In view of the 15 per cent limitation on charitable deductions, a person desiring to make a gift to a hospital in excess of 15 per cent of his adjusted gross income would be wise to spread his gift over a period of years so as to obtain the maximum income tax benefits.

For example, an unmarried person with an adjusted gross income of $100,000 a year and a net taxable income of $95,000 (after all exemptions and deductions except charitable gifts) may desire to make a gift of $45,000 to a charitable institution. If he makes the entire gift within one year, he will be entitled to deduct only $15,000 because his deduction in any one year is limited to 15 per cent of his adjusted gross income, resulting in a net income tax reduction at 1948 rates of $11,220. The net cost of his $45,000 gift will be $33,780.

On the other hand, if this person gives $15,000 a year for three years (a total of $45,000), he will be entitled to deduct the full amount of each year's gift, reducing his income tax each year $11,220, or a total saving of $33,660. The net cost of the $45,000 gift made in this manner will be $11,340. The federal government will, in effect, pay the remainder.

Under the "income-splitting" provisions of the Revenue Act of 1948, married persons who file joint returns are entitled to compute their tax as if one half of the total net income belonged to each and as if separate returns were filed. This "splitting of income" has the effect of reducing the tax brackets for married persons, especially when one spouse earns or actually owns all of the income, and thereby reducing the applicable tax rates. Therefore, the tax saving resulting from contributions by unmarried persons will be somewhat greater than that resulting from contributions by married persons having the same total income.

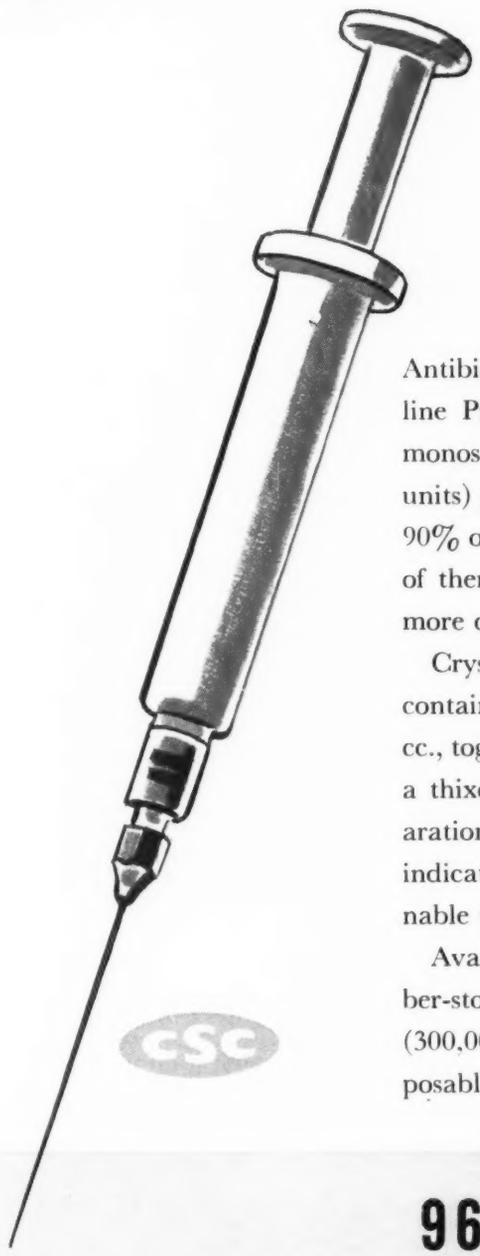
The accompanying tables show approximate federal income tax reductions that can be achieved through gifts by individuals to a hospital qualifying as a nonprofit charitable institution in 1948.

In addition to the income tax reductions outlined, substantial estate tax savings will also result to the individual from such gifts to a hospital by reason of the fact that the donor's net taxable estate is reduced by the amount of the net cost of such gift to the donor. The amounts of such additional tax savings are illustrated hereafter under estate taxes.

GIFTS OF PROPERTY

Gifts to a hospital need not be made solely in cash but can be made in any type of property. When planning to make such a gift the donor should consider whether the property has increased or decreased in value since the date of its purchase. The donor as a taxpayer is entitled to a reduction for income tax purposes of the full fair market value of such property on the date of the gift, irrespective of its original cost. There is no tax on any

A Single Injection Every Other Day



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Approximate Individual Income Tax Savings, 1948 Rates

UNMARRIED PERSONS

Net Taxable Income	Amount of Gift	Tax Savings	Net Cost of Gift
$ 5,000	$ 750	$ 171.60	$ 578.40
10,000	1,500	448.80	1,051.20
20,000	3,000	1,372.80	1,627.20
30,000	4,500	2,442.00	2,058.00
40,000	6,000	3,502.40	2,497.60
50,000	7,500	4,712.40	2,787.60
60,000	9,000	5,940.00	3,060.00
80,000	12,000	8,500.80	3,499.20
100,000	15,000	11,352.00	3,648.00
150,000	22,500	17,887.95	4,612.05
250,000	37,500	30,797.81	6,702.19

MARRIED PERSONS FILING JOINT RETURN

Net Joint Taxable Income	Amount of Gift	Tax Savings	Net Cost of Gift
$ 5,000	$ 750	$ 145.20	$ 604.80
10,000	1,500	343.20	1,156.80
20,000	3,000	897.60	2,102.40
30,000	4,500	1,773.20	2,726.80
40,000	6,000	2,744.60	3,255.40
50,000	7,500	3,854.40	3,645.60
60,000	9,000	4,884.00	4,116.00
80,000	12,000	7,004.80	4,995.20
100,000	15,000	9,424.80	5,575.20
150,000	22,500	15,708.00	6,792.00
250,000	37,500	29,370.00	8,130.00

increase in the value of the property over its original cost to taxpayer. As a result, there are substantial tax advantages in making a gift of property that has appreciated in value since its acquisition by taxpayer.

For example, an unmarried taxpayer having a net taxable income of $100,000 desiring to make a gift to a hospital or institution may own stock which he purchased more than six months previously for $4000 but which is now worth $10,000. If the taxpayer first sells the stock, he will incur a capital gain tax of $1500 on the $6000 profit. This tax reduces the net proceeds to $8500. If the taxpayer then gives the proceeds to the hospital he desires, he will have a deduction of $8500, which will reduce his income tax by $6507.60.

The net result will be that the taxpayer has made a gift of only $8500 at a cost to him of $3492.40 (the difference between the value of the stock, $10,000, and the income tax reduction of $6507.60). However, if the taxpayer gives the stock itself (instead of sale proceeds) to the hospital, he incurs no capital gain tax and will be entitled to deduct the full value of the stock, $10,000, reducing his income tax by $7656. The net result will be that the taxpayer has made a gift to the institution of the full $10,000 at a cost to himself of only $2344. In the event the taxpayer planned to sell the stock, the cost of giving it away to a hospital instead of selling it would be only $844 (the difference between $8500, the amount left after paying the capital gain tax, and the tax saving resulting from the gift).

On the other hand, if the property has decreased in value since its purchase, the donor will find it advantageous to sell the property first so as to establish a deductible capital loss and to give the proceeds of sale rather than the property.

CORPORATION INCOME TAXES

The federal statutes likewise permit a corporation to deduct from taxable income its contributions and gifts to educational, religious and charitable institutions up to an amount that does not exceed 5 per cent of its net income. This means that under 1948 tax rates, a corporation having a net income of more than $50,000 will reduce its federal income tax by 38 per cent of any amount so given. For example, a corporation having a net income (before the gift) of $1,000,000 could give $50,000 to a hospital and thereby reduce its federal income tax by $19,000.

GIFTS IN TRUST

The donor may establish an irrevocable trust reserving the income from the trust property to himself for life

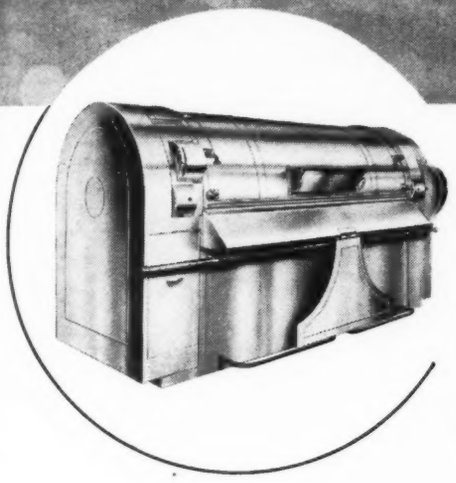
(*Continued on Page* 114.)

APPROXIMATE ESTATE TAX SAVINGS

Amount of Bequest	If Net Taxable Estate Is $50,000 Total Tax	Tax Savings	If Net Taxable Estate Is $100,000 Total Tax	Tax Savings	If Net Taxable Estate Is $250,000 Total Tax	Tax Savings
None	$7,000	.....	$20,700	.....	$65,700	.....
$ 5,000	5,900	$1,100	19,300	$ 1,400	64,200	$ 1,500
25,000	2,300	4,700	13,700	7,000	58,200	7,500
50,000	None	7,000	7,000	13,700	50,700	15,000
100,000	.....	.....	None	20,700	35,700	30,000
250,000	.....	.....	.....	.....	None	65,700

Amount of Bequest	If Net Taxable Estate Is $500,000 Total Tax	Tax Savings	If Net Taxable Estate Is $1,000,000 Total Tax	Tax Savings	If Net Taxable Estate Is $5,000,000 Total Tax	Tax Savings
None	$145,700	.....	$325,700	.....	$2,468,200	.....
$ 5,000	144,100	$ 1,600	323,850	$ 1,850	2,465,050	$ 3,150
25,000	137,700	8,000	316,450	9,250	2,452,450	15,750
50,000	129,700	16,000	307,200	18,500	2,436,700	31,500
100,000	113,700	32,000	288,700	37,000	2,405,200	63,000
250,000	65,700	80,000	233,200	92,500	2,310,700	157,500
500,000	None	145,700	145,700	180,000	2,153,200	315,000
1,000,000	.....	.....	None	325,700	1,838,200	630,000
2,000,000	.....	.....	.....	.....	1,263,200	1,205,000
5,000,000	.....	.....	.....	.....	None	2,468,200

U. S. Air Force Photo



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MEDICINE AND PHARMACY

CONTROL OF SURGERY

Can Be Solved Only by Coordinated Action

KARL S. KLICKA, M.D.

Director, Woman's Hospital, New York City

THE problem of controlling unintentional and unnecessary surgery is an old one. It was recognized by the medical professional societies thirty years ago when these organizations initiated their standardization programs with the intent to improve the quality of medical care rendered to the public. For physicians, specialty standards were determined and recognition was given to those who qualified by attaining superior abilities in their particular specialties. Hospital standards were set at a level that served as a challenge for each to improve the quality of medical care rendered therein. The response has been significant and today the majority of our hospitals can boast registration by the American Medical Association and a great many are approved by the American College of Surgeons. American medicine has progressed far and well since World War I and in large measure, credit for this goes to the aforementioned societies.

PROBLEM REMAINS A PUZZLE

In the pursuit of perfection, we are confronted with a problem that has puzzled those who wish to improve surgical standards beyond present levels.

Their code of ethics stamps surgeons in our society as men of superior integrity. The judgment and intellectual honesty of such men are not questioned. The medical profession can well be proud of the excellence of the great majority of its surgeons.

There are two minority groups among surgeons, however, that must be carefully watched. First, the group suspected of doing too many unintentional operations, owing to either a lack of judgment or errors in diagnosis, and second, the still smaller group that performs out-and-out unnecessary operations because of an interest in the fee which may at times exceed the interest in the patient. It must be emphasized that this second group fortunately is small, but the fact that it exists and prospers is sufficient reason to have prompted a general discussion of the problems provoked by it at the recent American Hospital Association convention in Atlantic City. The stimulus for the report came from this discussion.

EMPHASIS OF SUPERVISION

It is recognized that if progress is to be made in the control of unintentional surgery, more emphasis must be placed on teaching and supervising the younger surgeons. Unnecessary surgery will decline with the development of a surgical conscience. Our concern lies in the apparent lack of this development in certain surgeons and the method by which it may be encouraged.

The problem having been posed, we look for its solution.

Various technics have been tried by hospitals in an effort to improve the degree of excellence of the surgery performed in them. Clinical pathological conferences have been accepted as routine hospital procedure and it is customary to review all deaths occurring in the hospital at these meetings. A refinement of the C.P.C. is the tissue committee which has the responsibility of reviewing the records of all patients who have had an operation. The purpose of this, of course, is to determine the frequency with which a surgeon's preoperative diagnosis matches his postoperative diagnosis. The percentage of his surgical specimens showing no histopathology is also noted.

Both of these procedures are good as far as they go, but their value has certain limitations. They can be compared to the monthly financial statements presented to a board of governors by a hospital administrator. The contents of these reports are quite variable and their usefulness is considerably augmented when they are presented on a cumulative basis. As the months in a year pass, trends develop and as these are appreciated, corrective action can be taken. The twelve-month financial statement compiled at the end of the year is the most valuable statement of all inasmuch as the full performance of the year is portrayed therein.

CUMULATIVE REPORTS

If the value of clinical pathological conferences and the activities of tissue committees are to be utilized to the full, their reports should be maintained on a cumulative basis and submitted to the chief of staff in an annual report. This in essence is an audit of the surgery performed which, when reviewed, permits a realistic evaluation of the accomplishments of the individual surgeons of the hospital staff. A surgeon's bad months will be offset by his good ones. It is the average that counts. We are interested in a report based on a "series of cases" rather than one representing a few.

Is this necessary?

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This is a question for the medical profession to answer. As it is pondered, it may be well to pause for a moment to reflect upon the means customarily used by physicians in justifying their methods of treatment. No responsible business man would operate or be associated with a company or corporation that neglected to have its books audited annually. Dollars are admittedly important, but are lives any less so? This brings us back to the acknowledged integrity and intellectual honesty of most physicians, but is this a sufficient reason to exempt them from an audit of their work?

Professional audits are found in a few hospitals and from what is known about them, they are well accepted by the staffs of those hospitals. It is easy to shrug off the question by saying that the performance of an audit would be too difficult in this or that hospital, or that funds are not available for it. Actually the audit can be done quite readily and without too great a cost if the mechanism is not too complex.

INFORMATION IS ON RECORD

The information necessary for an audit is contained in all records kept in compliance with the standards of the American College of Surgeons. It is important that all patients, including emergencies, have a preoperative diagnosis written on the chart beneath the history and physical examination *before* the patient is taken to the operating room.

Periodically, information taken from records by an individual acquainted with them, can be recorded on work sheets. This is confidential information and so the job should be entrusted to the same person each year if possible. The record librarian or her assistant can easily do this. Certainly, a specialized auditor or statistician is not required for work of this sort. At the end of each year, the material and information collected on the worksheets can be transferred to a permanent record.

The most difficult to obtain is a record of the results of treatment inasmuch as this is subjective rather than objective and depends upon the surgeon's willingness to be exacting and completely honest.

The discharge summary sheet should include space for recording the end result of treatment and no chart should be accepted as completed until this information has been recorded. In general, this record will rather well match the others. For example, a surgeon who as a rule makes a correct preoperative diagnosis will naturally remove a high percentage of diseased organs. It follows, therefore, that a series of such patients should show a high percentage of cures. In contrast, one would be somewhat suspicious of the surgeon who reported a high percentage of cures in the face of a low "batting average" for matching preoperative and postoperative diagnoses, and who customarily removed an appreciable number of organs showing little or no pathology.

The audit should be kept in the office of the chief of staff where it can be studied and evaluated by the surgical board. The ultimate success or failure of the audit will be determined by the way in which it is used. If the approach of the surgical board is one of constructive criticism and guidance toward the surgeons with fair or poor showings, the staff will quickly learn to appreciate it as a guide and stimulus toward improvement. If the audit, however, is used as a club rather than a prod, it will quickly lose favor with all the surgeons who will fear it and, therefore, use devious means to sabotage it.

It should not be used as a means of determining staff positions or even staff appointments. It should rather be used as a guide to the senior surgeons, whose responsibility it is to watch the progress or lack of it among the members of their staff. A surgeon's weakness can be corrected only if it is known, and when corrective measures are taken with subsequent improvement of the surgeon, benefits accrue to him, his patients and to the entire staff. In the final analysis the reputation of a hospital staff depends not so much upon the abilities of a few of its members, but rather upon the work of all. A poor surgeon on a good staff is a reflection on the entire staff and no single member of it can afford to overlook this.

Of the various articles written on the subject of the control of surgery, specific reference is made to Dr. Norman F. Miller's treatise, entitled, "Hysterectomy—Therapeutic Necessity or Surgical Racket." It was published in the June 1946 issue of the *American Journal of Obstetrics and Gynecology*. It was necessary for Dr. Miller to assemble a considerable amount of material for this illuminating study and commenting upon this, he writes, "During the past few years, I have made two attempts to accumulate data of the type here presented; the first through hospital pathologists and the second through hospital directors, both of which resulted in failure. This, the third attempt, was successful because I obtained information where I should have sought it in the first place, namely, from the physicians themselves; a tribute to the cooperative spirit and scientific interest of American doctors."

Those who say that surgeons will obstruct the introduction of an audit are referred to the writings of Dr. George Gray Ward, chief surgeon emeritus of the Woman's Hospital, New York City. It was through his efforts and those of his colleagues that a professional audit was instituted at the Woman's Hospital in 1918. Of significance also is the fact that the audit has been continued until now, not due to the efforts of the hospital director, its pathologist or the board of governors, but rather because of the desire and interest of the staff itself.

AUDIT WILL HELP

The threat of government control of medicine looms greater with each passing year. Protagonists of this plan are ever searching for facts or incidents which can be used as criticism against our present method of practicing medicine. They surely must have "danced with glee" at the recent exposure of the rebate policy to ophthalmologists on the part of optical companies. The profession knows that unintentional and unnecessary surgery actually accounts for but a small proportion of all operations performed, but does the public know this? Articles have already appeared in popular magazines on the subject and more will be published as the vulnerability of the profession is more fully appreciated by those who make their living by publishing things of this sort. Isn't it about time we start keeping books on our activities?

The power to institute and popularize professional audits lies within the grasp of the three great voluntary organizations, the American Medical Association, the American College of Surgeons and the American Hospital Association. If they act individually, progress will continue to be slow, but an active coordinated participation by all three could do wonders. The challenge has been present for thirty years: need there be any further delay in meeting it?

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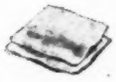
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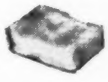
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NOTES AND ABSTRACTS

Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

STRUCTURE-ACTIVITY RELATIONSHIPS

The Newer Pharmacology

ONE of the earliest goals of pharmacologists has always been the relationship of chemical structure of drugs to their pharmacological action. Although few generalities or specific relationships have been elucidated, the pharmacologist now has a shorter term for such correlations. These correlations are now called structure-activity-relationships, and the term is abbreviated SAR.

Comparison of Natural and Synthetic Estrogens: By use of accurately scaled atomic models where one centimeter equals one Angstrom unit, it has now become possible to predict more accurately drug action from chemical structure. In certain isolated instances x-ray diffraction data are available on both naturally occurring hormones and their synthetic counterparts. Thus Schueler, working at the University of Chicago, found that diethyl stilbestrol has the same distance between the prosthetic oxygen groups as has the naturally-occurring estrone (Theelin). On this hypothesis the rest of the molecule (which differs in each instance) may be considered as a convenient method of separating two prosthetic oxygen groups to provide in this instance estrogenic action (Fig. 1).

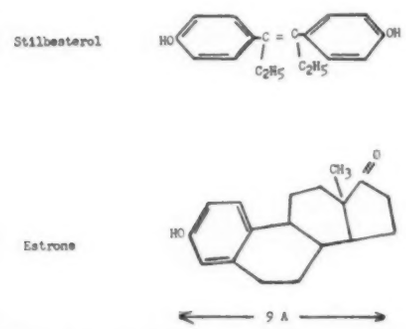


Fig. 1: Diethyl stilbestrol has the same distance between the prosthetic oxygen groups as has the naturally-occurring estrone.

Acetylcholine and Muscarinic Action: Recently, Pfeiffer, of this university, has extended this type of analysis of SAR to explain muscarinic (acetylcholine) action and the blocking of acetylcholine action (atropine action).

The potent aliphatic parasympathetic stimulant drugs can be easily fitted into a working hypothesis in which activity depends on oxygen groups and other substituting groups at a mean distance of 7 Angstrom units from a methyl on nitrogen prosthetic group (Fig. 2).

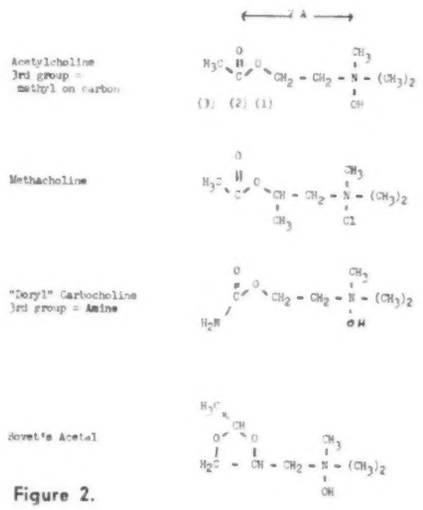


Figure 2.

Compound 4 was recently studied by Bovet and Fourneau who found it to be potent in a dose of 0.001 mg./kg. Apparently, if the interprosthetic distances are optimal, the receptors on the cell do not differentiate between ether, ketone, ester, or acetal oxygen atoms.

In analyzing any drug series for a possible common denominator of active prosthetic groups one must be guided by two criteria: (1) only the most potent compounds must be chosen for measurements, and (2) if possible, one or more of the derivatives should form rigid atomic models so that manual twisting of the molecule cannot be accomplished. The measurements on the rigid molecule must conform to the distances of the easily twisted aliphatic molecules. (We have found that the maximal distance obtainable on an aliphatic molecule conforms most closely to the measurements on the rigid molecule, for example, d-tubocurarine-aromatic and acetylcholine-aliphatic.)

The aromatic stimulants of the parasympathetic system may also be fitted into the hypothesis. Figure 3 reveals in pilocarpine, arecoline, neostigmin and physostigmine the three fundamental prosthetic groups at the same approximate interprosthetic distances that have been postulated for acetylcholine and its aliphatic homologues. Neostigmin was formerly

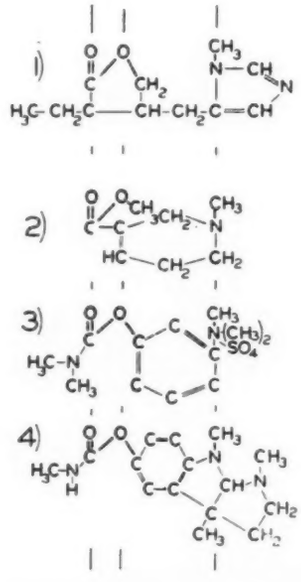


Fig. 3: Aromatic parasympathetic stimulant drugs: (1) pilocarpine, (2) arecoline, (3) neostigmin (prostigmin), (4) physostigmine.

thought to possess stimulant properties solely by virtue of its ability to inactivate choline esterase, but comparisons of DFP and neostigmin in animals and in patients with myasthenia gravis show definitely that the latter also has a direct acetylcholine-like action on striated muscle. This would be in accord with the interprosthetic distances of its three prosthetic groups.

Quaternization of the amino nitrogen of the aliphatic series invariably results in greater pharmacological potency, which may be ascribed to the greater availability of methyl on nitrogen prosthetic groups. In the aromatic series quaternization increases the pharmacological potency only when the interprosthetic distance is optimal. Thus, Stedman has shown that the ortho and para analogues of neostigmin lose potency when quaternized, while the meta analogue (neostigmin) becomes much more potent. The benzyl urethane analogues of neostigmin further indicate the critical nature of the optimal interprosthetic distance, since in these derivatives the ortho analogue is the most potent and its activity is enhanced by quaternization while the slight activity of the meta derivative is decreased by quaternization. This may be due to the greater freedom of single methyl groups on nitrogen which makes the N to C bond distance 1.47 A available when the interprosthetic distance is too large or small. Thus, the interprosthetic distances of pilocarpine, arecoline and physostigmine, while not optimal, may be compensated for by the fact that the methyl group is attached in each instance to a tertiary nitrogen and is freer to rotate toward or away from the oxygen prosthetic groups.

Atropine-like Inhibitors of Acetylcholine: If the potent inhibitors of acetylcholine stimulation are now studied (Fig. 4), one finds again the three prosthetic groups postulated for acetylcholine action at the same or nearly the same interprosthetic distance. In these instances, however, the prosthetic groups are contained in the center ridge of a large umbrella-like molecule. This "umbrella-structure" is analogous to the blocking moieties of other blocking agents which have recently been synthesized (*i.e.* benadryl, which blocks histamine action on various tissues, and dibenamine, which blocks most of the excitatory actions of epinephrin). The interprosthetic distances in dibutoline and E-3 are 7.0 A for the ketone oxygen to nitrogen methyl groups and 5.3 A for the ether oxygen to nitrogen methyl groups. Atropine interprosthetic distances cannot be calculated by the use of Hirschfelder models. A light stimulant action should be expected from some of these agents before blocking occurs. Some evidence for this is found in the action of dibutoline on heart rate.

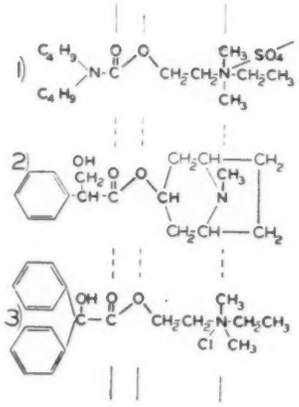


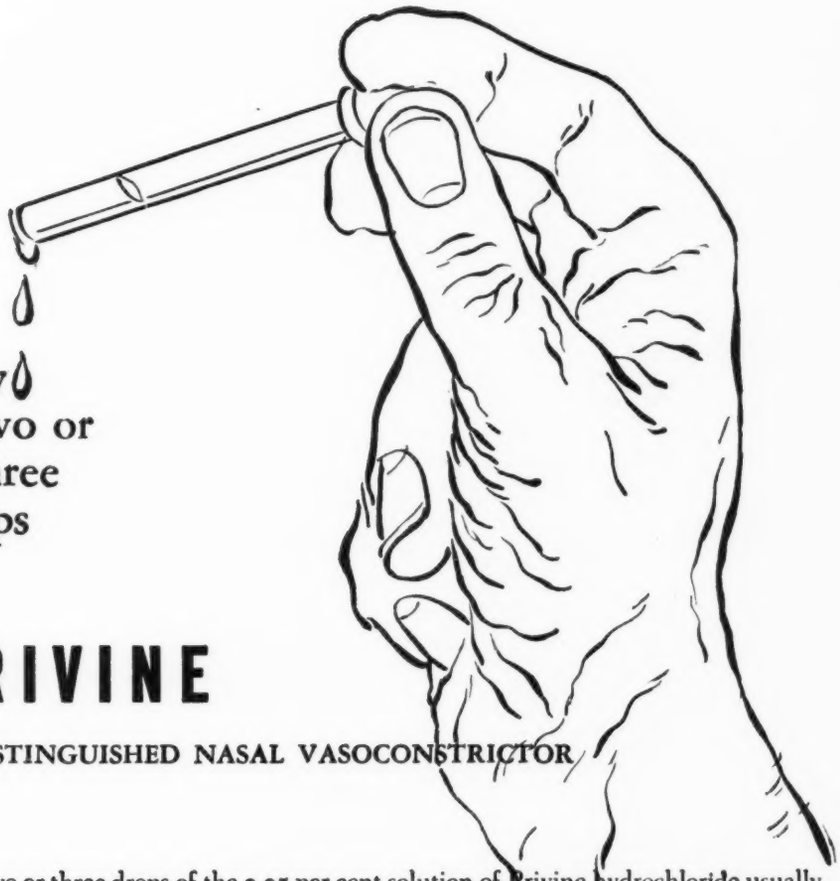
Fig. 4: Acetylcholine blocking agents: (1) dibutoline, (2) atropine, (3) Compound E-3 of Ing, Dawes and Wajda.

Inasmuch as modification or removal of the hydroxy group on the tropic acid portion of atropine analogues decreases the degree and duration of blocking, the hydroxy group must be considered as corresponding to the methyl on carbon prosthetic group of acetylcholine and the amine group of other parasympathetic stimulants. The simplest concept is that these blocking molecules adhere to the cell surface by means of their four or more prosthetic groups and by their continued adherence and difficult degradation prevent the smaller stimulant molecule from reaching the receptors on the cell. A second possibility which would account for the greater molar potency of atropine which blocks several mols of acetylcholine is that the umbrella-like atropine molecule may mechanically or electrostatically inactivate adjacent receptors on the cell surface so that these receptors are also unavailable for acetylcholine or other parasympathomimetic stimulants.

Other large molecules which contain only one or two of the acetylcholine prosthetic groups will show various degrees of blocking activity. Thus, methylene blue has an atropine-like action when perfused through the isolated heart. Unlike atropine, however, methylene blue can be easily washed off the cell surfaces. The intracellular methylene blue is inactive, so that, after washing, the heart muscle, although stained blue, will again respond to acetylcholine.

Action of Curare: Thus, measurements on atomic models of acetylcholine and other drugs with specific muscarinic action have shown that these agents contain two or three oxygen prosthetic groups at a distance of 5 to 9 A from one or more methyl on nitrogen prosthetic groups. Drugs which block the action of acetylcholine contain in addition to these prosthetic groups blocking or neutralizing moieties such as one or more butyl, or benzyl groups, or a benzhydryl group. Atropine is an extremely potent blocking agent for acetylcholine insofar as muscarinic effects are concerned. Its potency in blocking nicotinic effects of acetylcholine (on autonomic ganglia and on skeletal muscle) is extremely low. In contrast, d-tubocurarine blocks effectively the action of acetylcholine and other nicotinic agents on the skeletal muscle while it exerts little effect on autonomic ganglia, smooth muscle or glandular cells. In an attempt to correlate spatial relationship of prosthetic groups to drug action, it was of further interest to obtain inter-atomic measurements for the active groups of d-tubocurarine.

Using Hirschfelder atomic models the distance between the methyl on ring nitrogen and the three oxygen



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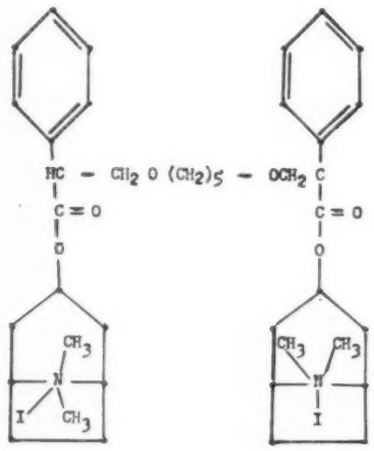
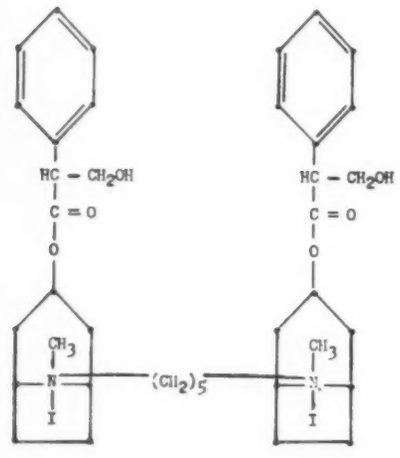
groups on the same hydrogenated quinoline ring of d-tubocurarine is within a radius of 5 to 9 A (this is in accord with the linear measurements between the prosthetic groups of acetylcholine). The two groups of oxygen atoms in d-tubocurarine average 9 A in their distance from each other and the nitrogens are 13 to 15 A apart. d-Tubocurarine, thus, resembles atropine in the "umbrella-structure" and the spatial arrangement of three oxygen groups to methyl on nitrogen. It differs from atropine in that it contains twin rows of these prosthetic groups instead of a single row. Hence, it would appear that the arrangement of twin rows of prosthetic groups is an important factor in endowing the molecule with its specific action on the neuromyal junction.

This hypothesis has been tested by a study of atropine and atropine-like homologues which have been joined together by a chain of approximately 9 A in length such as is provided by the normal amyl chain (Bovet et al. have shown that such amyl diethers have curare action). In making amyl bis molecules of atropine and the quaternary salt of atropine two derivatives have been made: (1) the dimethiodide of the amyl diether of atropine where two atropine molecules are joined through the tropic acid hydroxyl groups, and (2) the amyl di-quaternary compounds synthesized by connecting two atropine molecules through the tertiary nitrogen with pentamethylene di-iodide.



O – Amyl – O Diatropine Dimethiodide



N – Amyl – N Diatropine Dimethiodide

Fig. 5: Structural formulas of diatropines.

Table I—Relative Potencies of Diatropines

	Molecular Weight	MOUSE Lethal Dose 50% mgm./kgm.	MOUSE Head Drop Dose 50% mgm./kgm.	RABBIT Head Drop Dose 50% mgm./kgm.
1. Atropine Methyl Nitrate	366	11	5.5	8.5
2. Diatropine N-Amyl-N Di-iodide	902	1.0	0.6	0.35
3. Diatropine O-Amyl-O Di-iodide	929	0.8	0.6	0.32
4. d-Tubocurarine Chloride	695	0.14	0.08	0.15

These two diatropine compounds have the potencies shown in table 1 in comparison to atropine methyl nitrate and d-tubocurarine chloride.

The curare-like action of atropine is thus markedly enhanced by the twinning of quaternary atropine molecules through an amyl chain. Compared to atropine methylnitrate (eumydrin), both diatropine compounds are about twenty-five times more effective when tested on rabbits, and about ten times more potent in mice. They show a less marked increase in potency in the frog. d-Tubocurarine chloride, however, is approximately 2 to 2.5 times more effective in rabbits than is either diatropine derivative.

Both diatropine compounds exhibited a marked degree of specificity in their curarizing effects, as evidenced by the reversibility of their effects in frogs and rabbits. The ratio between curarizing dose (HD-50) and lethal dose (LD-50) for diatropine O-amyl-O dimethiodide in mice is 1.36 compared to 1.74 for d-tubocurarine and 2.06 for eumydrin. The effects of the diatropine compounds in rabbits were of short duration, and the recovery from paralyzing doses was materially aided by neostigmine.

The results furthermore stress the importance of one or more quaternary N atoms for curare-like action of these compounds. The curarizing effects of atropine in intact animals (frogs and rabbits) could only be demonstrated with doses which are convulsively or otherwise fatal to the animals (see table 1). In contrast, the curarizing effects of eumydrin and the diatropines are reversible, and death in mammals is directly due to the paralyzing effect on the diaphragm. Furthermore, the non-quaternary diatropine O-amyl-O diether (not listed in the table) has indefinite curare-like action, when compared with diatropine O-amyl-O dimethiodide.

The marked increase in curare-like action by twinning prosthetic groups in a blocking molecule confirms this prosthetic group analysis of the d-tubocurarine molecule. The anatomical implications of this study in regard to the striated muscle cell are extremely interesting. Smooth muscle, glands and heart muscle have the acetylcholine effect blocked by atropine with its single row of prosthetic groups but striated muscle is much more effectively blocked by blocking molecules containing twin rows of prosthetic groups when the mean distance between the oxygen atoms is 9 A.

The recent studies of Barlow and Ing on simple aliphatic di-quaternary diamines indicate that a chain length of C_{10} is optimal for curare-like action of the methylated diamines. These compounds are about as potent as d-tubocurarine but are not anti-

doted by neostigmine. These diamines provide a distance of 15 A which is in agreement with our measurements on the d-tubocurarine molecule where the distance between the nitrogens is 13 to 15 A. Thus the C_{10} chain should be used when the nitrogens are connected.

These studies raise many interesting questions and speculations. Does the neuromyal junction of striated muscle have a front and back door of receptors, both of which must be blocked simultaneously? Does attachment of a single atropine or eumydrin molecule on the striated muscle cell oppose the acceptance of an adjacent atropine molecule? Does this signify that the three oxygen prosthetic groups repel the similar groupings of an adjacent molecule? This might prevent two atropine or eumydrin molecules from occupying adjacent positions on the cell surface except with extremely high dosage when laws of mass action might operate rather than a possible adsorption phenomenon. From a teleological point of view the omission of striated (voluntary) muscle from the blocking action of atropine-like compounds may indicate the possible existence (at one time at least) of an atropine-like controlling chemical in the body. For obvious reasons of "fright and flight" the voluntary muscles would of necessity be excepted.

While these studies point to the future synthesis of practical curare substitutes, none of the presently studied compounds has been sufficiently evaluated to suggest its use clinically as a substitute for curare. Owing to the widespread action of these compounds on the neuromyal junctions the respiratory depression produced by large doses militates against curare-like compounds having a therapeutic index of more than two when the head drop dose is considered as the effective dose.

Further Working Hypotheses: One can further elucidate working hypotheses of the interactions of several pharmacodynamic agents. While these hypotheses aid in the explanation of many pharmacological observations the factual data to support the hypotheses can only be obtained over a period of years.

A blocking drug is one which contains in addition to the prosthetic groups of the stimulant drug certain blocking moieties such as benzyl, dibutyl, benzohydryl, and so forth.

Blocking Moiety	Anchoring Group	Drug
Benzyl | Phenyl	4-OH 4-OCH_3 4-Chlor	Neoantergan
Benzohydryl	4,4' dichlor	4 — chlor penicillin G
Thionyl	2 — chlor or brom	Chlorothen
4 amino quinolines	7 — chlor	Chloroquine
8 amino quinolines	6 — methoxy	Pentaquine

Drugs which act by blocking have the following characteristics:

1. They may follow an adsorption type curve of action (J. A. Wells-Benadryl).

2. They are effective at a low dose, for example, Atropine 1 mgm. T.D. man, and Benadryl 50 mgm. T.D. man.

3. They have a persistent action: Benadryl 4 to 6 hours. Atropine 4 to 8 hours. Conversely, drugs which act by competitive inhibition are characterized by:

1. Following the law of mass action.

2. Requiring an amount of drug to compete effectively with amount of stimulant drug in the body (tetraethyl ammonium chloride 500 mgm. T.D. intravenously).

3. Having a short duration of action (30 to 45 minutes) unless the blood level is maintained.

Potency of Prosthetic Groups: The relative order of potency of prosthetic groups *may* follow that of the general anesthetic agents.

Ethylene — Chloroform

$C = C,\ C - OH,\ C - OCH_3,\ C = NH,\ C = O, C = S, C - CH_3,\ C - Cl,\ C - Br$

Least potent — Most potent

Successful blocking moieties which have been used in the past are, in increasing order of potency, as follows:

Blocking Moiety	Drug
Dibutyl	Dibutoline
Benzyl	Pyribenzamine
	Atropine
Benzohydryl	Benadryl
	Lachesine
	Methadone
Thionyl	Thenylene
Phenanthrene	Morphine
Phenothiazine	Phenergan

Potency may be increased by the substitution of the following "anchoring" groups on the corresponding blocking moieties (see top of page).

An amine substitution instead of a chlor or methoxy "anchoring group" causes complete loss of activity.

"Loose ends" of blocking molecules should have terminal ethyl groups (as in the propionoxy above) or butyl groups to provide the longest duration of action.

When large blocking moieties are used, the point of attachment should be near the center of the molecule (Fig. 6).

Insofar as chemotherapeutic agents are concerned, it is possible that the antimalarial drugs and also penicillin are blocking compounds. In penicillin G the stimulant blocked might be glutathione, and in the antimalarial drugs the metabolite blocked is unknown.

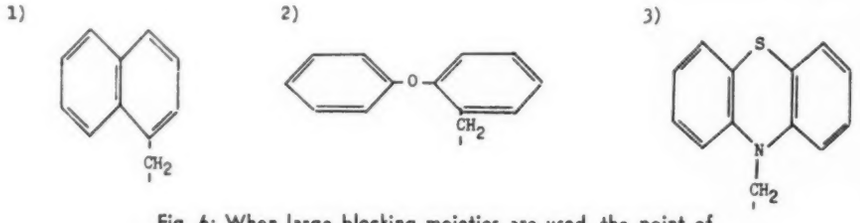
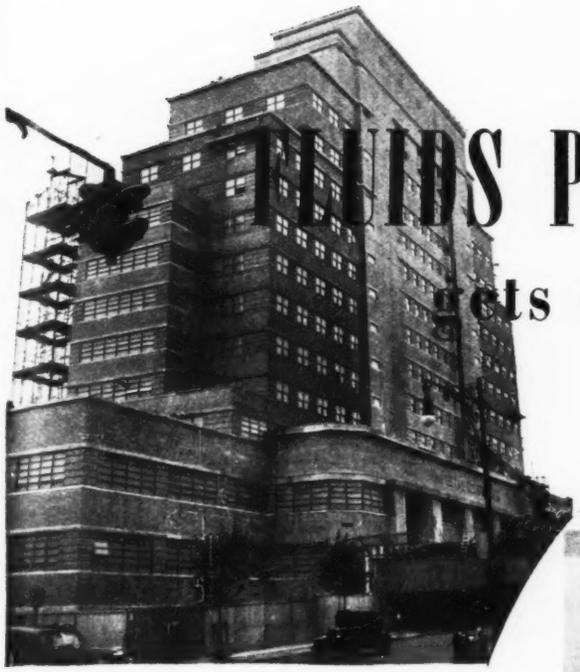


Fig. 6: When large blocking moieties are used, the point of attachment should be near the center of the molecule.

I realize that distribution of active prosthetic groups, while perhaps responsible for major drug action, is strongly influenced by the associated molecular structure, which must always be determined by animal experimentation. I further acknowledge that present studies may contain several inaccuracies, owing to the fact that interprosthetic distances have been calculated or measured from the meager data available on the interatomic bond distances of other organic compounds. More nearly accurate measurements should be made on these drugs by the physical-organic chemists so that pharmacologists can, in turn, define more accurately the prosthetic groups on molecules, interprosthetic distances, and the spatial relationship of the receptors on the surfaces of reacting cells.—C. C. PFEIFFER, M.D.



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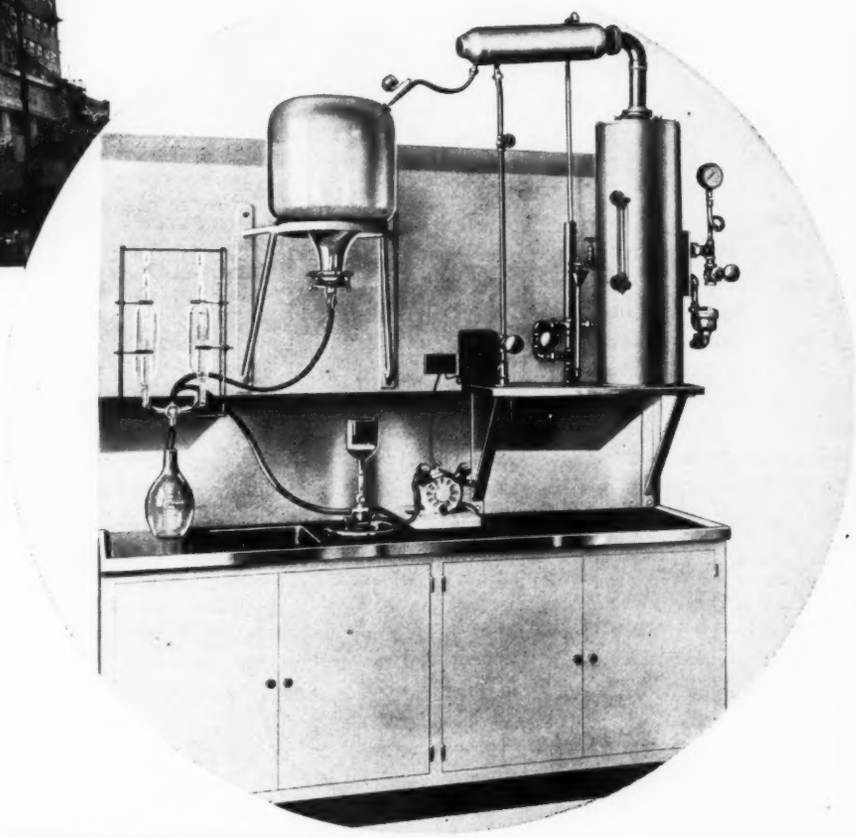

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BEHIND the human element in the tasty food and highly commended dietary service at Hamot Hospital, Erie, Pa., is a kitchen which was expanded and completely modernized following the completion of a Lanham Act project at the hospital which increased the bed capacity by one-third and doubled the dormitory facilities for students in the school of nursing. The modern kitchen equipment and efficient layout are utilized to the full by a well trained staff working under the capable direction of a dietitian who has a fifteen-year service record with the institution.

The kitchen project, completed in 1945, was designed to meet the war-time emergency expansion program to 300 beds, plus provision for further postwar expansion of the hospital to 500 beds, and included expansion of dishwashing facilities, remodeling of cafeteria equipment and addition of a receiving dock, animal room and garbage and refuse disposal services.

The project was financed by the federal government only to the extent the government believed adequate to cover the cost of facilities needed to provide food service to meet the immediate needs of the emergency war-time expansion program. In this program the government made an outright grant of $16,000, or approximately 25 per cent of the $63,000 total cost.

Seventy-two generous Erie industries and business concerns contributed the remaining $47,000 needed within a matter of weeks. A tribute to these donors and the government was made permanent through a large bronze plaque, listing the name of each contributor, erected on the wall near the entrance to the kitchen.

The first important task in providing adequate kitchen facilities was to increase the kitchen area. The former kitchen occupied 1096 square feet and served an average of 1200 meals per day. Under the building program, the kitchen was enlarged to a floor area of 3685 square feet. An average of 1650 meals are now served daily from the new kitchen. With relatively slight rearrangement and addition, this kitchen will be able to meet the needs of the current building program of the hospital for which funds have now been raised and plans and specifications are practically completed.

The walls of the kitchen are tile throughout with buff colored glazed blocks which are readily cleaned and are attractive to the eye. The ceiling is painted a complementary cool shade of green. Floors are of terrazzo to match the original section of the kitchen. Windows extend the entire length

BEFORE: Section of Hamot's kitchen before remodeling.

AFTER: Same kitchen; but who would ever suspect it?

of the north wall and half way down the east and west walls. Conventional lighting fixtures are used.

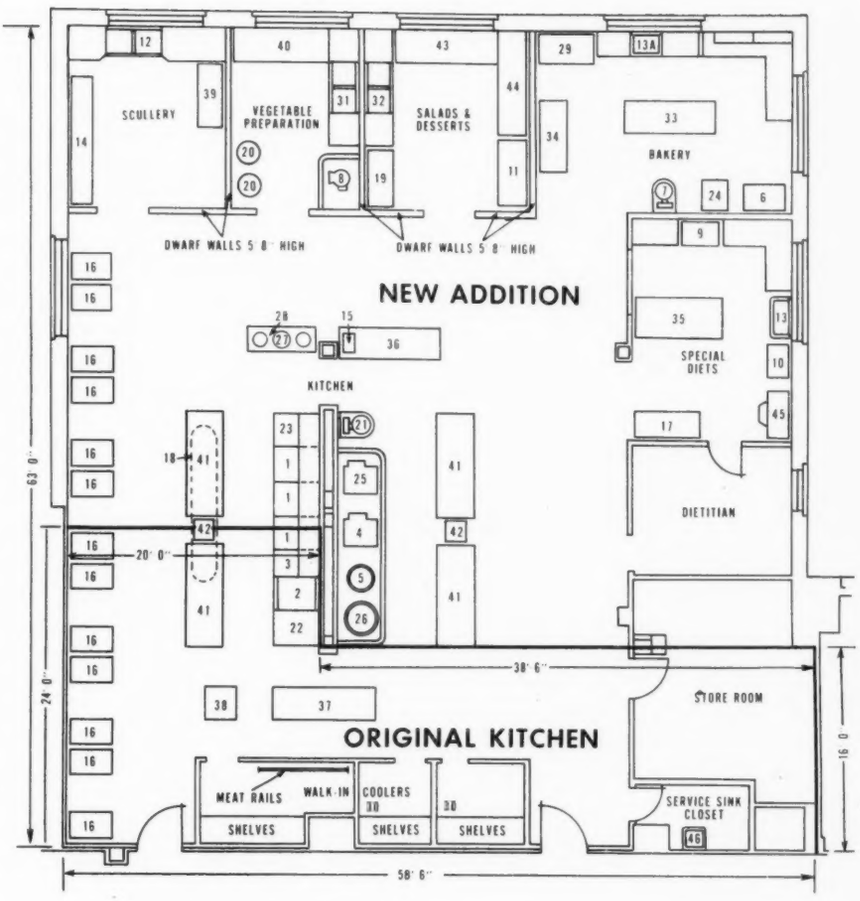
Extreme care was taken to use all available space to the greatest possible advantage. Ranges and ovens were backed to steamers and pressure cookers in an island located in the center of the kitchen. A mechanical ventilating system over the island serves all of this cooking equipment. A mixer, coffee making equipment and a table for cold meat slicing equipment are located at the north end of the island. The gas burning units used in the old kitchen were retained because of their serviceability. The new range and oven are heated by electricity.

The office of the dietitian was moved from its previous location across the hall into the kitchen proper; it is located approximately midway along the east wall of the kitchen. The glass walls of this office permit supervision of almost all parts of the kitchen from the dietitian's desk. On one side of the office is the kitchen for special diets; on the other are the storeroom for broken lots of case goods and a janitor's closet. Bulk storage of food is centralized in the stores department on the floor below the kitchen level.

A voice intercommunication system connects the dietitian's office with all sections of the kitchen. The communication system is also connected with the office adjacent to the kitchen which is occupied by the four assistant dietitians and with the employes' cafeteria which is located to the south of the kitchen.

Tray carts are located in the space between the dietitian's office and the central island. Provision for the electrically heated food carts is made along the west wall of the kitchen. These carts are heated electrically through wall outlets and are kept at the proper temperature until they are dispatched to the various floors of the hospital where they are again "plugged in" so that the food can be kept at the proper temperature until it is served to the patient.

A series of four cubicles separated by dwarf walls 5 feet 8 inches high is arranged along the north wall of the kitchen. One cubicle is the bakery



KITCHEN EQUIPMENT SCHEDULE

1. FORMER RANGES, MOVED
2. FORMER BROILER, MOVED
3. FORMER FRYER, MOVED
4. FORMER STEAMER, MOVED
5. FORMER KETTLE, MOVED
6. FORMER BAKE OVEN, MOVED
7. FORMER MIXER, MOVED
8. FORMER VEGETABLE PEELER, MOVED
9. FORMER DIET RANGE, MOVED
10. FORMER REFRIGERATOR, MOVED
11. FORMER ICE CREAM CABINET, MOVED
12. FORMER POT SINKS, MOVED
13. FORMER SINK, MOVED
13A. NEW SINK PLUMBING
14. FORMER PAN SHELVES
15. FORMER BREAD SLICER
16. FORMER FOOD TRUCKS
17. FORMER TRAY CART
18. FORMER PAN RACK, MOVED
19. FORMER COOLER
20. NEW REFUSE CANS
21. NEW MIXER
22. NEW ROASTING OVEN
23. NEW RANGE SECTION
24. NEW BAKER'S STOVE
25. NEW STEAMER
26. NEW KETTLE
27. COFFEE URNS
28. NEW COFFEE URNS STAND
29. NEW REFRIGERATOR
30. NEW COOLERS
31. NEW VEGETABLE SINK
32. NEW SALAD SINK
33. BAKER'S TABLE
34. NEW PASTRY RACK
35. NEW DIET RACK
36. NEW BREAD CABINET
37. NEW MEAT TABLE
38. NEW MEAT BLOCK
39. NEW WORK TABLE
40. NEW WORK TABLE
41. NEW COOK'S TABLE
42. NEW COOK'S SINK
43. NEW WORK TABLE
44. NEW WORK TABLE
45. NEW COUNTER SECTION
46. NEW SERVICE SINKS

This battery of electrically heated food carts is lined up along the west wall. Here, the food is kept at the proper temperature until carts are ready to be dispatched to the various floors.

for pastries, rolls and desserts; the second is for salad preparation, and the third is for vegetable peeling. The last in the series of cubicles is the scullery for washing and scouring pots and pans.

The dwarf walls were decided upon because of the additional ventilation and light allowed by this type of construction, which at the same time gives each unit the privacy required to carry out departmentalized work with greatest efficiency.

The south end of the kitchen is given over to three walk-in coolers set at varying temperatures, one for vegetables, one for dairy products and one for meats. Blower units are installed in all coolers so that defrosting is unnecessary. Before remodeling, the walk-in cooler facilities were located on the subbasement floor directly beneath the kitchen, which necessitated additional burdens of supervision and transportation.

At the time the kitchen facilities were expanded, the employes' cafeteria and dishwashing facilities were increased proportionately. At present, all dishwashing for the entire hospital is done in one central dishwashing room. This system will be superseded by decentralized dishwashing in the new hospital. It is believed that by decreasing the size of the present dishwashing room in the new building program it will be possible to extend existing cafeteria facilities in the space thus gained to make the building of additional cafeteria facilities unnecessary.

Adding to the enjoyment of the meals by the hospital personnel is the redecorated dining room in which the walls are painted a soft rose color, while the windows are colorfully decorated with the newest of nylon, noninflammable draperies. The ceiling has been sound conditioned and is painted white. The installation of a pay cafeteria system remains to be effected.

Because of the side hill elevation of the hospital, the kitchen, although on the basement level in relation to the main entrance, is one story above the ground. Since the subbasement level under the new kitchen is also above ground, it was found practical to build a full story of usable building space under the addition to the kitchen. A portion of this space was given over to use as a receiving entrance for all supplies and provisions for the hospital, and the remainder was assigned to use for garbage and rubbish disposal and for the animal room.

The disposal service and the animal room were so constructed as to be completely walled off from the hospital, with entrances removed from the hospital proper. Hospital personnel having business in any of these portions of the building must leave the hospital proper in order to enter these service facilities, thus eliminating any possibility of contamination from these important functional portions of the hospital.

Final planning of kitchen facilities for the building program as now completed includes provision for the following to be added to the present kitchen: an enlarged bakery; one additional range, and one additional steamer to be provided at the north end of the island; one additional walk-in cooler; a bain-marie; facilities for making our own ice cream, and storage space for eleven additional hot food carts. The space needed for these additional services will be provided to the west of the existing kitchen in accordance with plans made for these contingencies in 1945. The special diet kitchen will be relocated in the present bakery and the present diet kitchen will become the office for the assistant dietitians.

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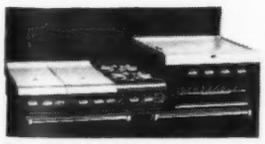

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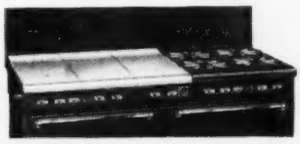

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FOOD FOR THOUGHT

Peanuts in Cornbread

Putting peanuts in the traditional southern cornbread is a simple, low-cost way to add flavor and nutritive value to this staple food of the South, Ouida D. Abbott of the Florida Experiment Station suggests.

Dr. Abbott believes that many families in the South could improve their diets for better nutrition simply by including peanuts in their daily cornbread or corn muffins. The peanuts give the bread more protein, fat and niacin—the anti-pellagra vitamin. If southern cooks made their cornbread regularly with the addition of chopped peanuts, Dr. Abbott believes there would be less pellagra in the South.

One-third ground raw peanuts to two-thirds cornmeal is the mixture she suggests. This mixture contains 15 per cent protein as against 9 per cent for cornmeal alone. It carries more than 17 per cent fat as against less than 4 per cent fat for cornmeal. Bread made from this mixture has six times as much niacin as plain cornbread.

Dr. Abbott recommends grinding raw peanuts in an ordinary food chopper with a fine blade and making up enough at one time for several days' supply. The ground peanuts should not be kept too long, however, because they eventually take on a rancid flavor.

The recipe Dr. Abbott uses calls for 1-1/3 cups cornmeal; 2/3 cup ground peanuts; 1 teaspoon salt; 2 teaspoons baking powder; 2 cups milk. The dry ingredients are mixed and then moistened with the milk. The use of milk instead of water gives added protein to the bread. No fat is needed in the batter when peanuts are used, but the pan should be greased before baking the bread.

Jelly Superstition

Some food superstitions die hard, even when the weight of scientific fact and long practical experience should kill them off. One mistaken idea which shows up each year is that beet sugar is not as good for making fruit jelly as is cane sugar. Grocers have reported that buyers are likely to discriminate between the two.

Cookery experts and sugar specialists of the U.S. Department of Agriculture agree that beet and cane sugars in refined granulated form give equally good results in jelly-making, canning or cooking. The two sugars are chemically the same.

To the consumer they say: If your jelly doesn't jell, don't blame either cane or beet sugar.

Peel for Flavor

Although it may take more time to peel apples before cooking them for applesauce, studies at the New York State Experiment Station show that the flavor of the sauce generally is better. When apples are cooked unpeeled and then strained, the sauce may have a bitter taste from the peel.

Flavor and color both are better if the apples are cooked rapidly in a covered pan. Long slow cooking destroys the delicate apple flavor and may darken the sauce. A tight cover on the pan helps hold in some of the volatile flavor or bouquet of the apple.

food flavors sing

Accent brings out the NATURAL flavors of the dishes you prepare. Ac'cent adds no flavor, no aroma, no color of its own.

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MY ADDRESS.....

Menus for January 1949

Ona Frances Stinson
McMillan Hospital
Charleston, W.Va.

1
Grapefruit Half
Canadian Bacon
•
Roast Duck With Dressing
Cranberry Sauce
Mashed Potatoes
Buttered Peas
Slaw
Hot Rolls
Ice Cream
•
Potato Soup, Crackers
Toasted Cheese Sandwich
Green Beans
Tomatoes
Peaches

2
Vegetable Cocktail
Scrambled Eggs
•
Baked Ham
Sweet Potatoes
Brussels Sprouts
Spring Salad
Baked Apples With
Raisin Sauce
•
Oyster Stew, Crackers
Hot Deviled Eggs
Baked Potatoes
Harvard Beets
Celery
Butterscotch Pudding

3
Stewed Peaches
Three-Minute Eggs
•
Steak With Gravy
Mashed Potatoes
Diced Rutabaga
Bing Cherry Loaf Salad
Chocolate Cake With
White Icing
•
Tomato Soup, Crackers
Macaroni and Cheese
Spinach With Lemon
Mixed Raw Vegetables
With French Dressing
Fruited Gelatin With
Custard Sauce

4
Orange Juice
French Toast, Sirup
•
Liver With Gravy
Parslied Potatoes
Succotash
Head Lettuce With
Mayonnaise
Cornbread
Ice Cream
•
Pea Soup, Crackers
Beef Rosettes
French Fried Potatoes
Stewed Tomatoes
Pear and Grated Cheese
Salad
Brownies

5
Applesauce
Link Sausage, Toast
•
Baked Chicken
Buttered Noodles
Glazed Carrots
Tossed Green Salad
Cherry Cobbler
•
Vegetable Soup, Crackers
Cheese Fondue
Potatoes in Jacket
Buttered Asparagus
Slaw
Peaches
Cookies

6
Grapefruit Sections
Poached Eggs
•
Roast Beef
Lima Beans
Cauliflower With Cheese
Sauce
Tomato Aspic Salad
Pears and Apricots
•
Consommé, Crackers
Creamed Chipped Beef on
Toast
Green Beans
Carrot Sticks
Icebox Cake

7
Stewed Prunes
Bacon and Eggs
•
Baked Halibut
Corn Pudding
Broccoli
Pineapple and Cottage
Cheese Salad
Muffins
Chocolate Pudding
•
Tomato Soup, Crackers
Salmon Loaf
Mashed Potatoes
Peas
Head Lettuce With
Thousand Island Dressing
Fruit Cocktail

8
Oranges
Sweet Rolls, Apple Butter
•
Salisbury Steak
Mashed Potatoes
Julienne Beets
Mixed Raw Vegetables
With French Dressing
Gingerbread With Lemon
Sauce
•
Mushroom Soup, Crackers
Vienna Sausage on
Stuffed Baked Potato
Spinach
Pear With Grated
Cheese Salad
Gelatin With Whipped
Cream

9
Bananas
Broiled Ham, Toast
•
Breaded Veal Chops
Baked Potatoes
Buttered Asparagus
Waldorf Salad
Hot Rolls
Ice Cream
Cookies
•
Chicken Broth, Crackers
Creole Spaghetti
Combination Salad
Peach Custard
Vanilla Wafers

10
Tomato Juice
Scrambled Eggs
•
Short Ribs of Beef With
Dressing
Browned Potatoes
Cabbage
Fruited Gelatin Salad
Rice Pudding
•
Vegetable Soup, Crackers
Creamed Chicken on Toast
Peas and Carrots
Stuffed Celery and Olives
Nectarines
Cookies

11
Grapefruit Half
Three-Minute Eggs
•
Spanish Meat Balls
Mashed Potatoes
Spinach
Carrot Slaw
Cherry Tapioca
•
Clam Chowder, Crackers
Cheese Soufflé
Lima Beans
Glazed Carrots
Head Lettuce, French
Dressing
Royal Anne Cherries
Cookies

12
Pineapple Juice
French Toast, Sirup
•
Liver Loaf With Tomato
Sauce
Corn Pudding
Green Beans
Perfection Salad
Chocolate Pie
•
Tomato Soup, Crackers
Steamed Wieners
Hot Potato Salad
Asparagus
Pickles and Olives
Peaches
Cookies

13
Stewed Peaches
Bacon, Toast
•
Chicken Pie
Buttered Peas
Pineapple and Date Salad
Ice Cream
•
Vegetable Soup, Crackers
Stuffed Baked Potato
With Cheese Topping
Kale
Canned Tomatoes
Fruited Gelatin
Cookies

14
Orange Juice
Scrambled Eggs
•
Broiled Codfish
Baked Potatoes
Buttered Mixed Vegetables
Molded Cranberry Salad
Muffins
Peach Cobbler
•
Creole Soup, Crackers
Tuna-Noodle Casserole
Green Beans
Celery and Pickles
Icebox Cake

15
Applesauce
Poached Eggs, Toast
•
Beef Stew
Spinach
Waldorf Salad
Cornbread
Ice Cream
Cookies
•
Cream of Asparagus Soup
Toast Sticks
Rice Omelet
Diced Carrots
Mixed Raw Vegetable
Salad
Boysenberries

16
Fresh Grapes
Link Sausage, Toast
•
Baked Chicken With
Dressing
Parslied Potatoes
Wax Beans
Sliced Orange Salad
Hot Rolls
Chocolate Blancmange
•
Celery Broth, Crackers
Golden Rod Eggs With
Parsley
Julienne Beets
Spring Salad
Strawberry Shortcake

17
Pineapple Juice
Poached Eggs, Toast
•
Baked Ham
Candied Yams
Broccoli
Tomato Aspic Salad
Gingerbread With
Whipped Cream
•
Bouillon, Crackers
Welsh Rabbit on Toast
Buttered Peas
Coleslaw
Rhubarb
Cookies

18
Grapefruit
Scrambled Eggs
•
Meat Loaf
Buttered Noodles
Toasted Carrots
Tossed Green Salad
Chocolate Cake With
White Icing
•
Mushroom Consommé,
Crackers
Chicken à la King
Buttered Mixed Vegetables
Stuffed Celery
Fruit Cocktail
Cookies

19
Baked Apple
Bacon, Toast
•
Roast Lamb With
Mint Jelly
Steamed Rice
Green Beans
Head Lettuce Salad,
French Dressing
Mincemeat Pie
•
Scotch Broth, Crackers
Hamburger on Open Bun
With Ketchup
Combination Vegetable
Salad
Peaches
Cookies

20
Bananas
Eggs in Shell
•
Minute Steak
Mashed Potatoes
Cauliflower
Apricot-Cream Cheese
Salad
Tapioca Pudding With
Chocolate Sauce
•
Chicken Soup With
Barley, Crackers
Creole Macaroni
Spinach
Canned Tomatoes
Apple Betty

21
Tangerines
Scrambled Eggs, Toast
•
Haddock With Tartare
Sauce
Potato Balls
Buttered Peas
Apple and Celery Salad
Cornbread
Ice Cream
•
Tomato Soup, Crackers
Salmon Croquettes
Broccoli
Chef's Salad
Blue Plums

22
Orange Juice
Sweet Rolls, Jam
•
Veal Birds
Mashed Potatoes
Shoestring Carrots
Combination Salad
Spice Cake With
Caramel Icing
•
Vegetable Soup, Crackers
Duchess Potatoes
Mexican Corn
Celery and Radishes
Fruited Gelatin
Cookies

23
Grapefruit Sections
Canadian Bacon
•
Roast Beef
Baked Sweet Potatoes
Diced Beets
Coleslaw
Hot Rolls
Cherry Custard
•
Pea Soup, Crackers
Crisp Bacon
Baked Potatoes
Asparagus With Cheese
Sauce
Canned Tomatoes
Ice Cream

24
Tomato Juice
Poached Eggs, Toast
•
Broiled Liver
Creamed Potatoes
Brussels Sprouts
Rainbow Citrus Salad
Boston Cream Pie
•
Consommé, Crackers
Spanish Meat Balls
Green Lima Beans
Head Lettuce With
Thousand Island Dressing
Pears and Light Sweet
Cherries

25
Stewed Apples
French Toast, Sirup
•
Baked Ham
Buttered Noodles
Peas
Spring Salad
Peach Pie
•
Clam Chowder, Crackers
Macaroni Puff
Green Beans
Tomatoes
Celery
Gelatin With Custard
Sauce

26
Orange Half
Three-Minute Eggs
•
Roast Pork
Corn Pudding
Julienne Beets
Spiced Fruit Salad
Vanilla Pudding With
Chocolate Sauce
•
Tomato Soup, Crackers
Scrambeld Eggs
Baked Potatoes
Spinach
Head Lettuce With
French Dressing
Baked Apple With
Whipped Cream

27
Stewed Prunes
Bacon, Muffins
•
Stewed Chicken
Steamed Rice
Buttered Carrots
Tossed Green Salad
Ice Cream
•
Broth With Barley,
Crackers
Spaghetti-Beet-Tomato
Casserole
Broccoli
Celery
Peaches

28
Grapefruit Half
Doughnuts
•
Salmon Loaf
Mashed Potatoes
Peas
Coleslaw
Green Gage Plums and
Apricots
Cookies
•
Vegetable Soup, Crackers
Cheese Soufflé
Potatoes in Jackets
Kale
Vegetable Perfection Salad
Chocolate Pudding With
Marshmallow Topping

29
Vegetable Cocktail
Scrambled Eggs, Toast
•
Meat Loaf
Green Lima Beans
Head Lettuce With
French Dressing
Lemon Pie
•
Pea Soup, Crackers
Creamed Chipped Beef on
Toast
Buttered Mixed Vegetables
Waldorf Salad
Gelatin With Cream
Cookies

30
Fresh Grapes
Eggs in Shell
•
Roast Turkey With
Dressing
Whipped Potatoes
Asparagus
Celery and Radishes
Ice Cream
Cookies
•
Potato Soup, Crackers
Grilled Cheese Sandwich
Mixed Raw Vegetable
Applesauce
Cookies

31 Stewed Peaches, Toast, Jelly • Steak With Gravy, Parslied Potatoes, Green Beans, Pear With Grated Cheese Salad, Gingerbread With Lemon Sauce • Scotch Broth, Crackers, Liver Loaf, Tomato Sauce, White Lima Beans, Spinach With Lemon, Fruit Cocktail, Cookies

Ready-to-eat or cooked cereals are offered on all breakfast menus.

MAINTENANCE AND OPERATION

THEY LIKE ACOUSTICAL CEILINGS

EVERETT W. JONES

AN ARTICLE on "What Kind of Floors and Ceilings Do You Want?" appeared in the December 1946 issue of The MODERN HOSPITAL. The section on acoustical treatment questioned the advisability of installing acoustical materials in kitchens and other food preparation areas. This statement caused a great deal of discussion, and the author decided to make a thorough investigation.

In discussing the situation with the sanitary engineers of the U.S. Public Health Service and the architects and engineers of the Division of Hospital Facilities, U.S.P.H.S., it appeared that there was some feeling against acoustical treatment in food preparation areas because of some experiences in kitchens many years ago. Approximately fifteen years ago, several reports were received of vermin being found in certain types of acoustical treatment in kitchens. Whether these reports were accurate or not is impossible to determine at this time. Everyone agreed that it would be wise to make a rather thorough study of the situation at present.

Accordingly, The MODERN HOSPITAL sent out a comprehensive questionnaire to 414 representative hospitals in all sections of the country. Up to the time of the tabulation of the returns, the surprisingly large number of 225 replies, representing a return of 54 per cent, had been received. Since this type of questionnaire ordinarily does not draw more than a 15 to 20 per cent return, the unusually high figure of 54 per cent testifies to the widespread interest of hospital executives in acoustical treatment. The accompanying tabulation gives a complete summary of all replies received.

Experience in industrial plants and business offices has pretty conclusively proved that noise is dangerous. It

TABULATION OF QUESTIONNAIRE REPLIES ON ACOUSTICAL MATERIAL

Total Questionnaires sent out—414. Total number of Questionnaires returned —225 (54%)

1. DO YOU HAVE ACOUSTICAL MATERIAL ON CEILINGS OF YOUR KITCHENS? (FOOD PREPARATION AREAS)

Yes—75 No—149 Of the 149 answering "no" to this question, 26 indicated that they did have acoustical material in the following areas:

Serving pantries and dishwashing rooms	14
Floor kitchens	9
Cafeterias	3

2. WHAT TYPE DID YOU USE IN AREAS UNDER NO. 1 ABOVE?

Perforated metal faced acoustical tile backed by rock wool	17
Drilled fiber board block (Holes do not go completely through)	54
Perforated asbestos—cement board backed by rock wool	15
Acoustical plaster	8
Acoustical tile (Openings do not go way through; openings are irregular rather than round holes)	17
Special types not mentioned in questionnaire	4

3. WE ALL UNDERSTAND THAT VERMIN, DIRT AND GREASE CONTROL IS A PROBLEM IN ALL KITCHENS. HAVE YOU EXAMINED THE ACOUSTICAL MATERIAL ON THE CEILINGS OF YOUR KITCHENS TO SEE IF IT COLLECTS MORE OR LESS DIRT, GREASE AND VERMIN THAN OTHER PARTS OF THE KITCHENS—AND WHAT DID YOU FIND?

Examination reveals more dirt (Dirt only.* No vermin found.)	17
No problem	76

*Dirt found only in kitchens with inadequate hoods and ventilation.

4. HOW OFTEN DO YOU HAVE TO PAINT THE MATERIAL TO KEEP IT LOOKING NEAT AND CLEAN?

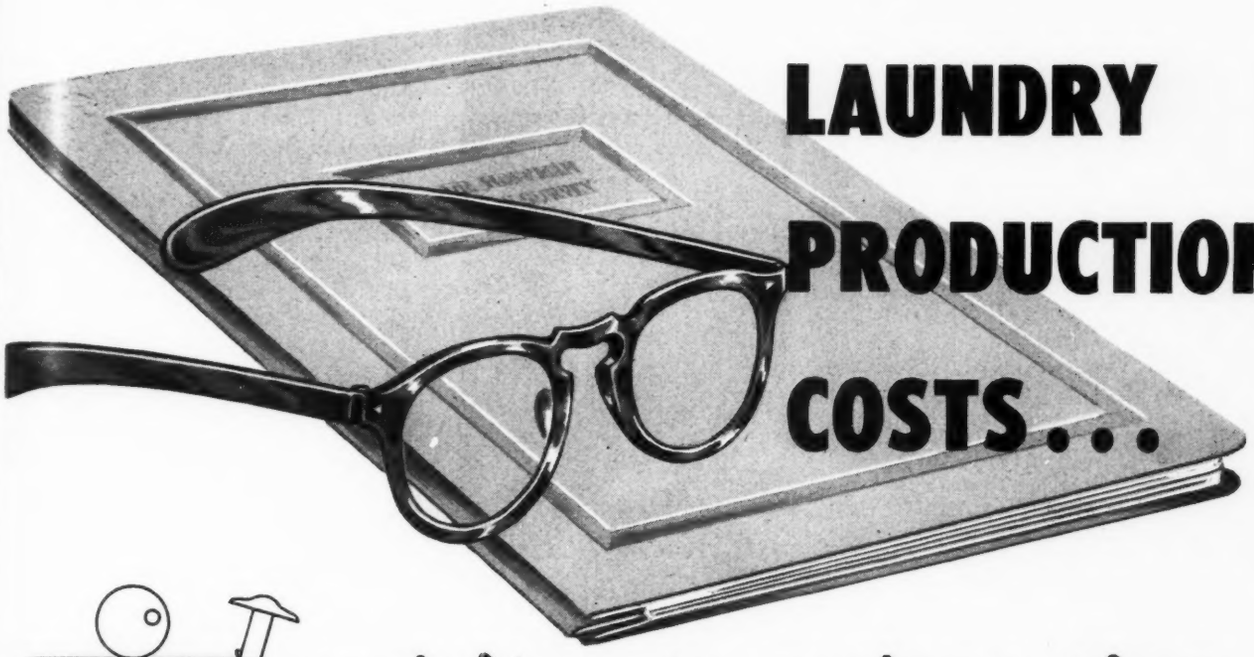
Every year	9	After fifteen years	1
Every year and a half	2		
Every two years	13	Frequent washing—painting intervals same as ordinary walls	16
Every three years	25		
Every four years	8		
Every five years	6	Washing and cleaning often—no paint	13
Every six years	4		
Every seven years	1	Clean with wallpaper cleaner	5

5. PLEASE LIST ANY ADVANTAGES OR DISADVANTAGES WHICH YOUR EXPERIENCE INDICATES.

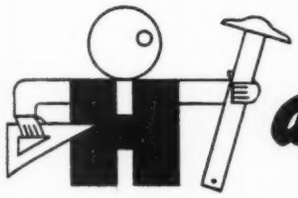
ADVANTAGES		DISADVANTAGES	
Eliminates noise	9	Excessive moisture area causes deterioration and lack of adherence	15
Reduces noise	42	Rust difficulties with metal material in moist and steamy areas	4
Easy to maintain	3	Paint peels over steam areas	1
Aids employe efficiency and morale	8	More difficult to clean	5
Excellent results	9	Question use in some areas	2
Nice appearance	2	Use depends on hospital layout	1
Extensive use should be made	2	Material becomes drab (although regularly cleaned) when paint is not used	5
Greatest addition to the hospital	2	Acoustical plaster not as satisfactory	5

6. DO YOU STILL HAVE AREAS IN THE HOSPITAL WHERE YOU WOULD LIKE TO INSTALL SOME TYPE OF ACOUSTICAL MATERIAL?
Yes—178 No—40

For a new look at your



LAUNDRY PRODUCTION COSTS...

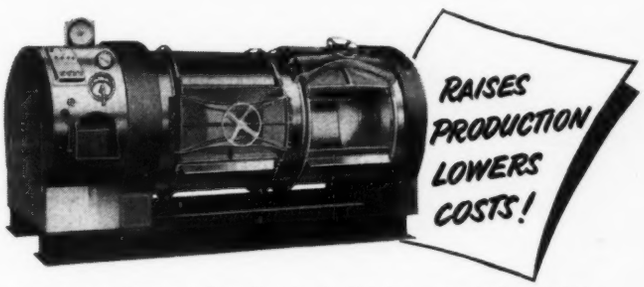


...and how to reduce them—

Is increased laundry output per square foot worth the investment of a few moments of your time? In the case of hundreds of hospital officials, this selfsame proposition already has helped to save floor space, save time and labor, save linen, fuel and supplies.

Without obligation to you, a Hoffman Laundry Engineer will survey your entire laundry operation. To discover how you can obtain abundant linen supplies at lowest cost per patient day, he will analyze your costs, survey your linen requirements and suggest linen control systems. Furthermore, he will furnish efficient new laundry layouts and recommend new equipment to help you attain adequate, balanced production at overall low cost.

You may be sure that your Hoffman Laundry survey is complete, detailed, authoritative. It is backed by Hoffman's long-time experience in assisting large and small institutions of every type to achieve new records of successful laundry operation. For that new or modernized laundry you're planning, ask for this valuable survey service now — without obligation.



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Process linen every minute — washing and rinsing are continuous. Spent solutions are flushed without dropping the liquid level. Thus, big savings in production time and labor — also, avoids "filtering out". 38, 44 and 48-inch cylinder diameters.

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distracts individuals' attention from their work and therefore reduces human efficiency. Excessive noise is irritating and nerve racking. It causes frayed tempers and, hence, personality clashes.

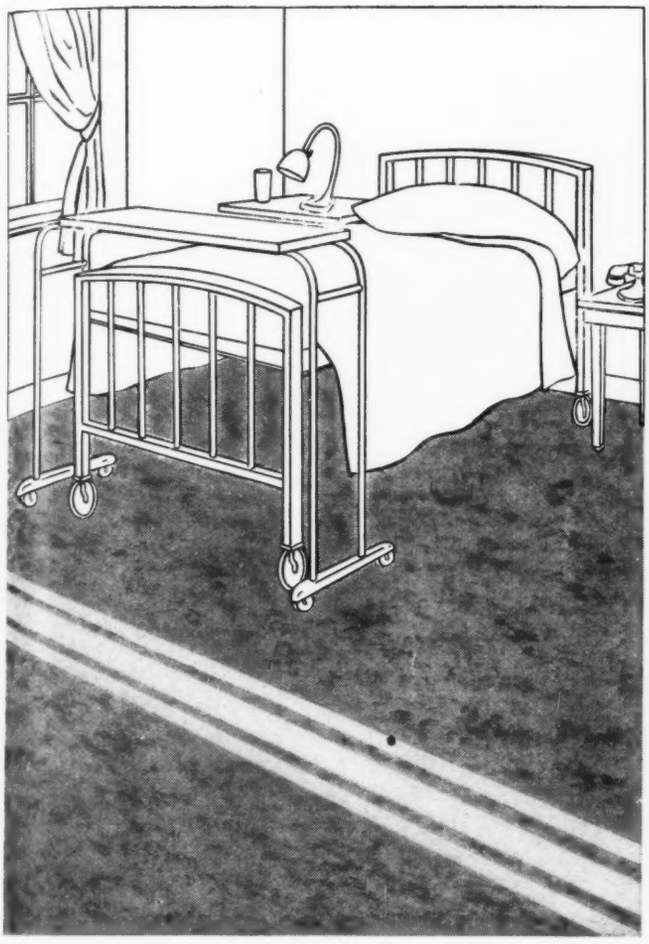
Patients, their friends and relatives enter the hospital in an abnormal frame of mind, therefore, things irritate them more than would normally be the case. Any suggestion or sign of confusion in the hospital upsets them. We all know that excessive noise suggests confusion. Noise creates an atmosphere of fear, causing a general feeling of uneasiness. This can and often does result in a definite lowering of vitality. Noise is an enemy of concentrated thinking and because of this, it interferes with the steady work performance that is so essential in any business or industry, and doubly so in hospitals.

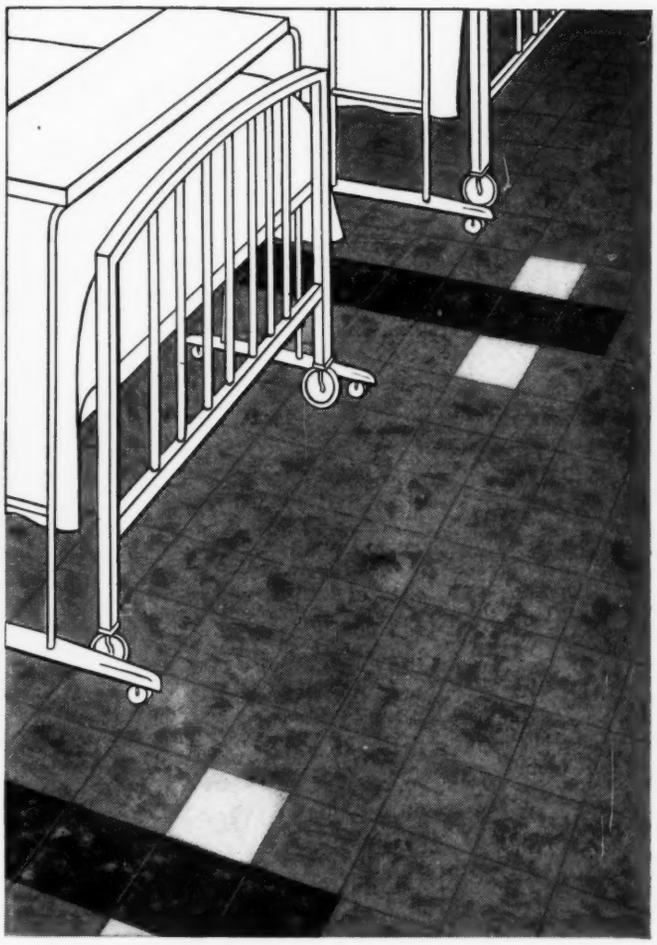
The reduction of noise through good acoustical treatment relieves employes of tensions and strains, which results in fewer mistakes, a steadier rate of work, and less absenteeism from the job.

Probably the noisiest places in hospitals are kitchens, food preparation areas, pot washing and dishwashing rooms. It therefore seems important that these areas be thoroughly soundproofed. The results of our questionnaire indicate that the old notions as to the advisability of soundproofing food preparation areas can now be completely discarded. Not one of the hospitals reporting found any evidence of vermin in the acoustical material in their kitchens. It is interesting to note that only seventeen out of the large number in which soundproofing has been in use in the kitchens found any excessive dirt. A checkup indicates that these are institutions in which adequate hoods and exhaust ventilation over food preparation equipment are lacking.

Architects, hospital consultants and hospital executives contemplating the installation of acoustical treatment in food preparation areas can now approach the problem unencumbered by any thought that present-day types of acoustical material are not sanitary in kitchens.

Inasmuch as sound reduction in other important areas, such as nurseries, labor and delivery rooms, is also of great importance, it would seem that no one need worry about installing acoustical material in these or any other areas of a hospital.





"Linoleum is the best hospital floor!"

"We didn't always have linoleum on the floors, and when I say it's best, I'm speaking from experience. For several years now, Armstrong's Linoleum has given us a kind of service we never got before.

"You can see for yourself how it brightens our rooms and corridors. It gives the hospital a cheerful air that helps convalescence. And notice that it is quiet and resilient underfoot. That's a really important feature, especially for our staff who are on their feet all the time.

"From an economy standpoint, we've found that Armstrong's Linoleum lasts for years—and that its cleaning costs are low. Another good reason why I say Armstrong's Linoleum is the best hospital floor."

"Asphalt tile is the best hospital floor!"

"We built this hospital on a limited budget. To hold costs down, some of our first floor area was not excavated. Our architect selected Armstrong's Asphalt Tile because it was low in cost and because it was the one flooring that could be used over these unexcavated areas as well as our upper floors.

"We got the floor designs we wanted at no extra cost since the tile is laid one block at a time. The bright colors give the entire hospital a pleasant, airy appearance. Our janitors like it, too. They say that it is exceptionally easy to keep clean. And our books show that maintenance costs are even lower than our budget figures."

There's room for argument about the comparative merits of Armstrong's Linoleum and Armstrong's Asphalt Tile. Sometimes one is a better selection, sometimes the other. It all depends on your own needs.

Asphalt tile usually costs a little less, but linoleum is more resilient and quieter underfoot. Both floors are long wearing, about equally easy and inexpensive to maintain. If your subfloor is concrete in contact with the ground, be sure to use Armstrong's Asphalt Tile.

Most people think linoleum has first call when it comes to beauty because of the very wide range of colors and patterns in which Armstrong's Linoleum is made. On the other hand, Armstrong's Asphalt Tile is an attractive materi l. Laid a tile at a time, it has almost unlimited design possibilities.

To get the floor that's best for you—to weigh advantage against advantage and help make up your own mind—**drop us a card and we'll send you two booklets**—one about Armstrong's Linoleum and the other about Armstrong's Asphalt Tile. If you want to compare samples or actual floors, see your local Armstrong floor contractor. Armstrong Cork Company, Floor Division, 5712 State Street, Lancaster, Pa.

ARMSTRONG'S FLOORS

LINOLEUM (A) *ASPHALT TILE*

LINOTILE® ★ RUBBER TILE ★ CORK TILE

HOUSEKEEPING

Conducted by Alta M. La Belle and Jane Barton

HOUSEKEEPING STARTS WITH ORGANIZATION

MRS. MILDRED F. O'DONNELL

Executive Housekeeper
Mount Auburn Hospital
Cambridge, Mass., and
Director
Institutional Housekeeping Course
Boston University, Boston

This discussion starts the series of lectures on executive housekeeping which was inaugurated at Boston University in September under the co-sponsorship of the National Executive Housekeepers Association and the Massachusetts Hospital Executive Housekeepers Association. Other lectures to follow will deal with the organization of a hotel housekeeping department, job evaluation and training, purchasing, decorating, tools and equipment, management problems and safety.—The EDITORS.

WHEN one is applying for a position as an executive housekeeper in a hospital it is well to know a few pertinent facts: first, to whom you are responsible; second, what your duties entail; third, what the policies of management are pertaining to salary rates, vacation periods, raises and sick leave, and fourth, general rules that concern yourself as well as the employes working under you. It seems to me that a contract is a good, business-like way to begin for both your employer's protection and your own.

BASIC STRUCTURE THE SAME

The basic structure of hospital housekeeping is the same as that of hotels. But it has not been entirely recognized as an independent department in hospitals as it has in hotels. Broken down into units the department is organized as follows: executive housekeeper, assistant housekeeper, secretary, linen room staff, sewing room staff, porters, maids, housemen and night crew. The function of each of these separate groups differs somewhat from that of hotels.

First, the difference lies in the physical aspects. Hospitals cover large areas. This creates a problem in staffing divisions, in the delivery of supplies, such as linen and drugs, and in a good overall supervision.

The second difference lies in the close association with the nursing department. Great care must be taken that these two departments do not overlap. In past years nursing supervisors have had under their direction all the people in their immediate area, *i.e.* maids, housemen and their own nursing staff.

Herein lies the cause of constant friction because of the lack of understanding between housekeeping department and nurses. Many nurses still interfere with housekeeping procedures. The process of educating the nurses will be slow, but it will one day come about through management intervention so that this situation will no longer exist, for housekeeping in hospitals is a specialized field and must not be confused with the functions of nursing.

To avoid interference and friction a routine for each and every ward and private room area should be planned to meet the need of that specific place. Talk the routine over with the head nurse, modify it to her need, and then ask her to leave the maid, the houseman or the porter alone to perform his or her duties. The nurse must understand that housekeeping people are under the supervision of the housekeeper only. There cannot be two "bosses." Should the housekeeping employe prove unsatisfactory or difficult she should be turned back to the housekeeper and retrained, shifted to another part of the house, or released.

If one were to ask a supervising nurse if she would consider it proper for the housekeeper to ask one of her nurses to go on errands, or to help to change draperies, or to fill in at the linen room she would be quite horrified; yet many nurses still continue to send the maid on errands, ask her to carry trays, go for a patient in the x-ray room—and then wonder why that maid has failed to complete her day's work.

SETTLE DIFFERENCES AT ONCE

Should constant friction continue to exist, meet with your nursing staff, talk over your differences, then *settle* them once and for all. I repeat that it is an educational process—and a slow one. Many a good hotel housekeeper has taken a hospital position as executive housekeeper and given it up in despair because of nursing interference.

On the other hand, housekeepers must take into consideration the problems of the nursing department. When a nurse calls for a mattress for a fracture patient who is on his way from the accident room, send it to

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TIMES have changed—the pace of progress has been accelerated—since the original '49ers plodded their way westward. The urge of the pioneer to seek something better still flourishes. Revolite '49er Roll Covers reflect this pioneering spirit. *Now*, we offer you an improvement on the famous Revolite Roll Covers that thousands of laundries have used to turn out millions of better bundles faster and at less cost. Again, Atlas proves it can make the best even better.

The new, finer weave of Revolite '49er Roll Covers produces finished work of new smoothness and beauty—work that looks cleaner and fresher . . . reflects great care and high-quality workmanship.

Of course, Revolite '49er Roll Covers carry the famous Revolite guarantee of *six months* of satisfactory service. *And remember this:* Usually, you'll find Revolite rolling out better bundles much longer than the six months demanded by the guarantee.

Write, phone, or wire for detailed information on Revolite '49er Roll Covers, and a copy of the Revolite guarantee.

her immediately. If she needs a change of mattress on the bed of a patient who is sitting up for a short time, get it to her quickly. Should she have a number of incontinent patients and need additional sheets, send them to her. Or should she ask to have the wall of the premature nursery washed, take the wall washer off whatever job he is doing and have the work done. The nurse, in all probability, has no babies in the nursery at that moment and must have the work done. These are "musts." A nurse is not unreasonable in making such requests.

The housekeeping department is in a position to contribute much in the way of help to every department in the hospital. Through constant observation the housekeeper can see ways and means of helping the doctor, the nurse, the operating room staff, the patient, the maintenance department and almost everyone with whom she has contact.

KEEP IMAGINATION WORKING

She can make a plastic boot for the patient who is having leg soaks to cut down the use of too many sheets; she can cover straps on operating tables so they can be easily washed; she can see to it that operating rooms, delivery rooms and central supply rooms get their linen early so that they can make up material for autoclaving; she can make a pair of orthopedic pants for the patients in traction to prevent embarrassment from exposure; she can take old pieces of heavy cloth and make them into drop cloths for the painters. It is up to her to keep her eyes open and her imagination working if she is to be of real help.

I recall a genito-urinary specialist who was exasperated because lap stockings on his cystoscopy patients kept falling off every time they got on and off the table. We took a pair of scrub pants, put boots on the ends of the legs, cut out the perineal area and reinforced it, with the result that the patient had a garment that tied around his waist and stayed on. Patients and doctor were very happy about the whole thing.

There is much more to hospital housekeeping than cleanliness, color schemes and good teamwork.

The assistant housekeeper is the alternate for the executive housekeeper and usually acts as the "trainer" for new employes, as well as inspector. Records, time cards, correspondence, typewriting of routines and the answering of the telephone are allocated to the secretary.

Linen rooms either are centralized or are small rooms in which reserve material is kept. If the linen room is centralized it should be headed by a supervisor who marks and issues new linen and discards old linen. She also trains those who work with her.

In the sewing room there should also be a supervisor who cuts and makes up new material. She supervises the work of other seamstresses. It is much cheaper to make slip covers and draperies on the premises. If there is no seamstress qualified to do this, one employe can be sent to a good school for instruction and taught the necessary rudiments of this work.

It is well to plan on an alternate for both the linen room and the sewing room supervisors so that there is someone to take their places during vacations or in case of illness.

Maids in hospitals do the cleaning of all areas, both patient-occupied and public. They do not make beds except in the nurses' home, interns' quarters, or director's home.

Porters attend to the disposal of garbage and trash and the dispensing of linen and drugs.

Housemen take care of floor and wall maintenance. They move supplies and furniture. A houseman must be taught the differences among various types of floors, how they are maintained, what is used in the way of equipment and supplies, and the procedures involved. The same is true in wall maintenance. It behooves the housekeeper to know her floors. Plain and covered floors are expensive. Proper care is imperative.

Night cleaners are comparatively new in hospitals. In the past, public areas were cleaned during the day with a great deal of confusion and inefficiency. Now, in most institutions the night crew comes in and does the work during the hours when the areas are not occupied. It is well to have a crew manager but if there is none available each man can have his own assignment and the housekeeper can inspect his work the following morning. Good work, however, is done only if there is adequate supervision.

This discussion would not be complete if we neglected decorating and redecorating. Hospitals fall heir to all kinds of things: furniture, pictures, bric-a-brac. Be certain when decorating to find out what can be disposed of and what must be kept. You won't like some of the things that you must keep but there they must remain, nevertheless.

In more and more institutions, such work as window washing and wall washing is being done on a contract basis. The concern that offers the lowest bid on a contract is not always the best. Much care must be taken to inquire into the status of the company with which you plan to do business. It is far better to pay a higher rate and get good work than to pay a cheaper rate and get poor work.

Most hospitals do not employ a hostess. Therefore, the housekeeper must act as one. She sets up rooms for dances, lectures, teas, board meetings and for buffet suppers. When food is involved she works with the dietary department. Dates must be checked with the various departments to take care of these functions.

CONSIDER NEW EQUIPMENT

Before completing this lecture we should take into consideration some of the new equipment that is available. There are maid's carts for private room areas; vaporizing machines for the control of cockroaches; vacuum cleaners on wheels for general cleaning and for taking up water after mopping; plastic brushes with nylon bristles; toilet brushes with ears so that rims of toilets can be cleaned, and innumerable other things. The professional magazines are good sources of information. Your purchasing agent will also be glad to pass on to you information about new and tried articles.

This may seem a complicated array of facts but, like food, if taken in small bites and chewed well, it is easily assimilated.

One parting word of advice. Don't forget that employes have their "off" days, even as you and I, so don't be too hard on them when they do not seem to be doing their best. Mary may have a sick child at home, or John may be worrying about how he is to meet this month's rent. Your organization will work more smoothly if you take these human elements into consideration. For what is organization but people—human beings with feelings, emotions and faults, even, I repeat, as you and I.

Do You Have Patients Who Need This Comfort?

The Everhot Automatic Electric Blanket meets the need for constant, unvarying, warmth within the bed. Compensates for loss of body heat. Supplies warmth without the excessive weight, discomfort and uneven distribution of other bed warming methods. Over a million electric blankets are in use today in homes, hospitals and institutions, assuring restful relaxation regardless of room temperature.

There are many reasons why the Everhot Electric Blanket serves this need best. It is made of all wool yarns woven on a sturdy cotton warp—75% wool, 25% cotton—for better laundering qualities. Everhot wiring will outwear the blanket. Everhot binding is wider and of better quality than the average. Underwriters Laboratories approved of course.

Everhot Electric Blankets are the products of the same company that builds Ideal Food Conveyors and equal quality and dependability are assured.

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The Everhot Comfortrol is the outstanding advancement in the electric blanket field. The dial setting is readily visible at all times and easily adjusted by a person lying in bed. Each position on the dial is automatically illuminated and also indexed with a detent spring so that adjustment can be made by eye, ear or touch, in the dark. Unlike other control devices the component parts are mounted on a shock proof metal chassis within the exterior plastic shell and cannot be affected by damage to the plastic case.

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A crystal-clear, transparent, tough Plastic Case with zipper closure is supplied with every Everhot Blanket.

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Please send me complete information about your special offer to hospitals interested in electric blankets.

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THE LEGAL ASPECTS OF GIVING

(*Continued From Page* 82.)

with the vested remainder passing to an eleemosynary institution at the termination of the trust. If a hospital qualifies as an exempt institution, there is no federal estate tax upon the property when the donor passes on, resulting in estate tax savings. In addition, the donor is entitled to deduct for income tax purposes in the year the trust is created the value of the remainder interest computed according to actuarial tables (up to 15 per cent of his adjusted gross income). Under such a trust arrangement the donor can obtain a present income tax saving without reducing his present or future income and can reduce the estate taxes payable on his estate.

In addition to the income tax deductions allowed by the federal statutes for gifts to a nonprofit educational institution, all gifts, devises and bequests to such institutions also are completely exempt from federal gift and estate taxes.* As a result, substantial estate tax savings may result from such gifts and bequests, by reason of the fact that the taxable estate is reduced by the amount of the gift, bequest or devise.

For example, a gift of $50,000 by a donor with a net taxable estate of $250,000 prior to the gift would reduce the federal estate tax of such donor at the time of his death by $15,000. This saving in federal estate taxes would result whether the gift was made by the donor during his lifetime or as a bequest by last will.

These substantial estate tax savings may be obtained even though the bequest is not outright and immediate but is subject to a prior life estate. A testamentary trust may be established by will under which the income from the trust property is to be paid to a named beneficiary or beneficiaries for life and the property is to pass to a hospital upon the death of the beneficiary or beneficiaries. The estate will be entitled to deduct the value of the charitable remainder computed accord-

*The federal estate tax law allows a specific exemption of $60,000 so that the tax applies only to the amount of the net estate in excess of $60,000. For purposes of simplification, the $60,000 exemption has been already deducted in the tables and examples given except when specifically indicated otherwise. For example, a reference to a net taxable estate of $250,000 would involve a total net estate of $310,000.

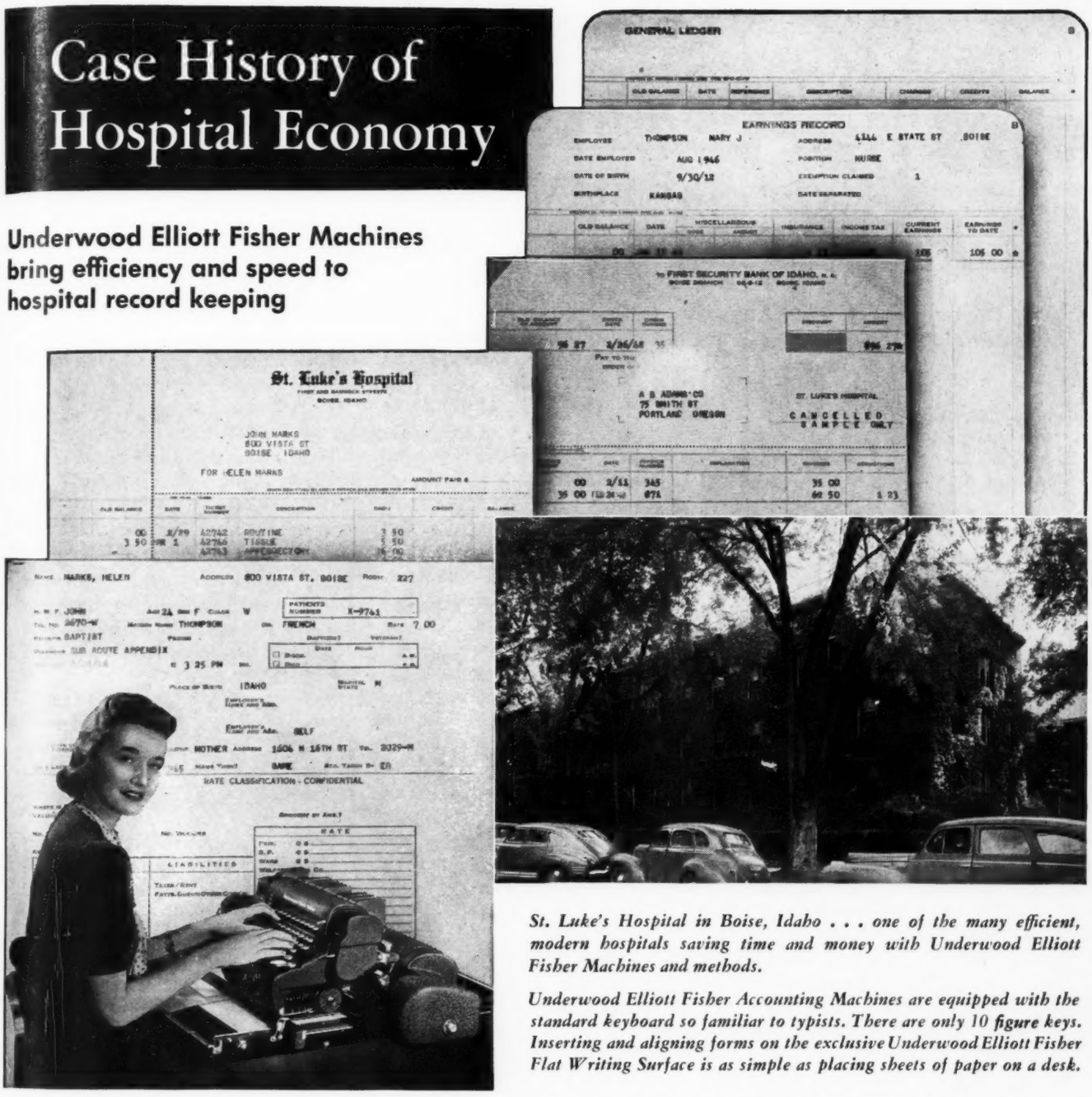
A marital deduction is allowed under the provisions of the Revenue Act of 1948 so that the estate of a married person may be further reduced as much as 50 per cent by the value of property passing to the surviving spouse and meeting the conditions enumerated in the law. For example, a married man whose net estate before the $60,000 exemption or marital deduction is $1,120,000 may leave $560,000 outright to his wife free of estate tax. The balance of $560,000 after taking the marital deduction would be further reduced by the $60,000 exemption so that the net taxable estate would be only $500,000.

However, any property passing to the surviving spouse so as to qualify for the marital deduction will be includable in the estate of the survivor upon his or her death. Therefore, it may be advantageous, as for example when both husband and wife have relatively equal substantial estates, to leave the estate in such manner that it would not qualify for the marital deduction but by the same token would not be added to the spouse's estate, as for example leaving the estate in trust with income to the spouse for life.

To determine the most advantageous method of leaving his estate, the taxpayer should consult his attorney.

Case History of Hospital Economy

Underwood Elliott Fisher Machines bring efficiency and speed to hospital record keeping



St. Luke's Hospital in Boise, Idaho . . . one of the many efficient, modern hospitals saving time and money with Underwood Elliott Fisher Machines and methods.

Underwood Elliott Fisher Accounting Machines are equipped with the standard keyboard so familiar to typists. There are only 10 figure keys. Inserting and aligning forms on the exclusive Underwood Elliott Fisher Flat Writing Surface is as simple as placing sheets of paper on a desk.

Your hospital, too, like this modern institution, can speed up the preparation of complete admitting and accounting records.

St. Luke's uses only two electrically operated Underwood Elliott Fisher machines . . . one Writing and one Accounting Machine. With these they prepare all of the following:

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2. Patients' Accounts Receivable Records.
3. Accounts Payable Records.
4. Employee Payroll Records.
5. General Ledger Records.

All detailed admitting information is recorded in a single interview, using a six-part form. The reverse side of one of the forms is used as the Patient's Ledger Account.

Charge and credit entries are posted simultaneously to all related accounts receivable records—the Patient's Statement, the Patient's Ledger Account and the Daily Journal. Accounts are "balanced" immediately after each entry with mechanical proof of the accuracy of all postings.

Similarly, the related accounts payable records including the Voucher-Check, the Vendor's Ledger and the Purchase Journal or Check Register are all posted in one writing—an operation which is fast and simple with Underwood Elliott Fisher's exclusive Flat Writing Surface.

The hospital's payroll records are no problem. As in the case of accounts receivable and payable, much time is saved by preparing the Pay Statement, the Pay Check, the Employee's Earnings Card and making the entry to the Payroll Summary in one operation.

Postings to the General Ledger Accounts are made with the same machine, with the same speed and with mechanical proof of accuracy.

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ing to actuarial tables. The resulting decrease in tax and increase in the amount of property remaining after taxes will result in an increased annual income for the beneficiary or beneficiaries.

To illustrate, a man with a wife aged 65 and no children has a net estate of $5,000,000 (before the $60,000 exemption). If he leaves his estate outright to his wife, the estate tax would be $968,800. This tax would reduce the estate to $4,031,200, with an annual income to the wife at 4 per cent of $161,248. On the other hand, if he leaves only one-half of his estate to his wife outright or in such manner as to take full advantage of the marital deduction provided by the Revenue Act of 1948 and the balance of his estate in trust for his wife for her life with remainder over to a charitable institution, the estate tax (computed in accordance with actuarial tables provided by the tax regulations) would be approximately $369,000. This tax would reduce the estate only to $4,631,000, with an annual income to the wife at 4 per cent of $185,240, or approximately $24,000 more than in the case of the outright bequest.

A gift of real property may offer substantial advantages to the donor's estate. In many cases it eliminates the difficulties and expense of appraisal, since its value is immaterial to the federal taxing authorities.

ESTATE TAX SAVINGS

The accompanying schedule of approximate estate tax savings is computed on the basis of the federal estate tax only, without allowing for possible credit for state inheritance and estate taxes. Additional savings may result in many states by further inheritance tax savings. In each case the amount of net taxable estate shown is the value of the net estate, after deducting the $60,000 exemption but before deducting the amount of the charitable gift, devise or bequest.

In computing the amount of the net taxable estate, the proceeds of life insurance generally must be included even though payable to beneficiaries other than the insured's estate. In addition, jointly held property must be included except to the extent that the original consideration for the property was furnished by the survivor. However, the amount of any bequest (which meets certain legal conditions) to a surviving spouse is deductible up to a maximum limit of 50 per cent of the "adjusted gross estate" (generally the net estate before deducting the marital deduction, charitable bequests and the $60,000 specific exemption).

SAVINGS BY LIFETIME GIFTS

The tax advantages of a gift during the donor's lifetime over a testamentary gift are readily apparent. The lifetime gift not only removes the property from the donor's estate with consequent savings in estate taxes but also entitles the donor to an income tax deduction (lost in the case of a testamentary disposition).

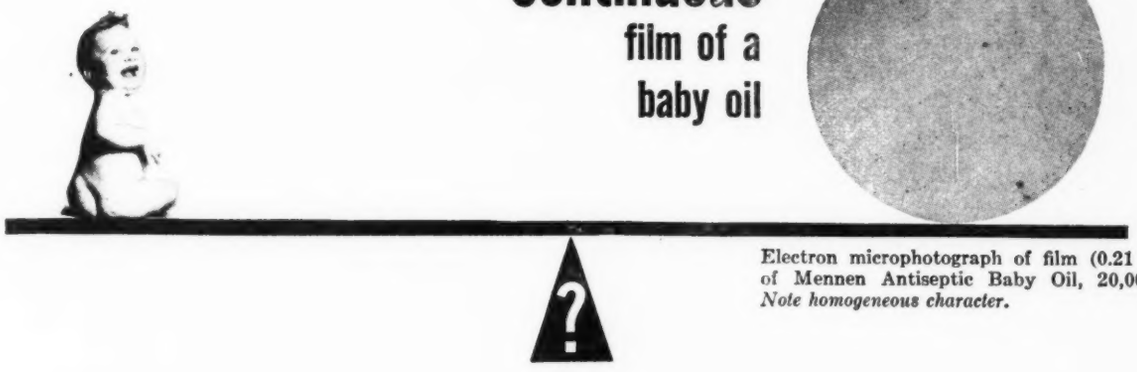
For example, an unmarried person has an annual net taxable income of $100,000 and will have a net estate of $1,060,000 before deducting the $60,000 exemption. If he makes no charitable gifts or bequests, his estate tax will be $325,700, leaving his heirs $734,300. If he makes a bequest of $100,000 to a hospital, his estate tax will be reduced to $288,700, leaving his heirs $671,300 after taxes and the charitable bequest. The net cost to his heirs of the $100,000 gift will be $63,000.

On the other hand, if during his lifetime he makes gifts of $15,000 a year for six years and a gift of $10,000 in the seventh year, a total of $100,000, his income tax deductions (at 1948 rates) will save him a total of $74,619,60 in income taxes, reducing his estate $25,380.40 (the amount not recouped by income tax savings).

This reduction of his estate will reduce his estate tax by $9390.75 to a tax of $316,309.25, leaving his heirs $718,310.35 (only $15,989.65 less than if no gifts had been made). The actual cost of such a gift of $100,000 planned wisely would be less than 16 per cent of its face amount. The remaining 84 per cent of the gift is borne by the federal government.

The organization of a program that will properly interpret to prospective donors the attractiveness of giving to a hospital, and incidentally effecting a tax saving for the donor, is only half the battle. The successful completion of the task depends upon how effectively hospital administrators utilize the material in approaching prospective donors. There is no easy way to obtain gifts, but sound interpretation will certainly help to persuade prospective donors to consider a hospital in their bequests.

which protects infant skin better?



Electron microphotograph of film (0.21 mm.) of Mennen Antiseptic Baby Oil, 20,000 X. *Note homogeneous character.*

Electron microphotograph of film (0.21 mm.) of a commercially marketed baby lotion, 20,000 X. *Note jagged particles, irregularity.*

A challenging comparison of the protection afforded infant skin by baby oil vs. baby lotion, is provided by the electron microphotographs reproduced above from a leading medical journal.*

Reports the author: "The film of the baby oil[1] gives a rather blank picture, and shows no micellar or lacunar features; it is homogeneous in appearance except for occasional blemishes due to isolated dust particles. Pictures of the oil-in-water emulsion[2] show numerous jagged particles in the order of magnitude of 0.3u, presumably traces of the stabilizing agent and other crystalline ingredients, left after evaporation of the aqueous phase."

Oil Shields Better. *It may be concluded without hesitation that the homogeneous oil film affords greater protection against penetration by common infant skin irritants than does the discontinuous, irregular layer of lotion.*

Oil Has No Effect on Perspiratory Activity. The physico-chemical behavior of perspiration on the surface of the skin is such that it does not remain confined beneath a layer of oil.

More than 3,400 hospitals, the majority of those important in maternity work, use Mennen Antiseptic Baby Oil routinely in the nursery.

mennen antiseptic baby oil
provides continuous film to protect better

*Elsner, H., "A Method for the Study of the Penetrability of Liquid and Semi-solid Films Used in Skin Protection", Journal of Investigative Dermatology. Vol. 10, No. 4, 1948

1. The oil used was Mennen Antiseptic Baby Oil.
2. A commercially marketed Antiseptic Baby Lotion.

How They Divide the Nursing Load

(*Continued From Page 54.*)

nurse or student, from 11:30 p.m. to 7:30 a.m. This generally is sufficient, though, of course, if more are needed we arrange accordingly."

Twenty administrators replied to the question: "Have the doctors on your staff expressed any opinion about the quality of nursing service rendered by auxiliary nursing personnel?" In sixteen cases, it was indicated, the doctors found auxiliary nursing service satisfactory. One staff thought the service was "only fair," one expressed a preference for all-graduate service, and two groups frankly thought the auxiliary service was unsatisfactory. In three of these four hospitals both practical nurses and nurse's aides furnish service; the fourth hospital employs only aides in the auxiliary group.

The direct cost of nursing service was reported as varying from $2.11 to $5.50 per patient per day. The average cost was $3.92. However, it seems likely from some of the responses that the cost figures given are not comparable. It may even be that some of the reported costs ($5.40 per patient day in a thirty-bed hospital employing only eight graduate nurses, for example) include charges that are not properly considered direct nursing service costs.

Whether this is the case or not, there is no correlation between nursing cost and the graduate nurse-auxiliary worker ratio as reported by these hospitals. The highest reported cost, $5.50, occurs in a hospital with a ratio of 1.8 auxiliary workers, including students, to 1 graduate nurse. The average ratio for all hospitals in the group is 1 to 1.9. The lowest cost, $2.11, was reported by a hospital in which the ratio is 1 to 0.9. The lowest ratio of graduates to auxiliaries was 1 to 6, reported by a 125 bed Southern hospital for which no nursing cost figure was given. The highest ratio, one graduate to 0.3 auxiliary, was reported by two hospitals with nursing costs of $4.54 and $4.64.

While the sample is too small to be significant, the ratio of graduate nurses to auxiliary workers in this group of hospitals was noticeably higher in the East, median in the Midwest and West, and lower in the South.

While only three of these hospitals now offer practical nurse training, it is possibly worthy of comment that ten hospitals reported that they had explored or were exploring the advisability of working with public school authorities toward the establishment of such training programs.

Nineteen of the hospitals offer on-the-job training for nurse's aides. Especially where schools of nursing are in operation, apparently, this training takes on some formal aspects, with classroom and demonstration time as well as learning-while-working under the supervision of graduates, head nurses and supervisors.

A detailed plan for nurse's aide training was submitted by one of the hospitals, the Corning Hospital at Corning, N.Y., and is presented on page 54.

Inquiring Photographer Gets The Picture

"All 3 Agree on C.P.P."

FROM COAST TO COAST, REPORTS LIKE THESE KEEP COMING IN:

Hospital Superintendent: "I've been a hospital superintendent for over 17 years, and know from experience that Colgate-Palmolive-Peet Company has a soap that appeals to my staff and patients alike."

NURSE: "Nursing has taught me that my patients seem more at ease when the hospital is as much like home as possible. You'd know what I mean if you saw them brighten up when they find their favorite soap awaiting them!"

Purchasing Agent: "In my seven years of purchasing experience, I've learned a surefire way to buy soaps that satisfy everybody! I let the C.P.P. salesman solve my soap problems and make suggestions. Yes, sir, my job is easier and nobody ever complains!"

PALMOLIVE—liked by everybody—meets the highest hospital standards in purity—a favorite with patients and nurses alike!

CASHMERE BOUQUET is a big favorite in private pavilions because women like the delicate perfume of this hard-milled luxury soap.

COLGATE'S FLOATING SOAP is made especially for hospital use. Its purity, mildness and economy meet the most exacting hospital requirements.

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NEWS DIGEST

"Corporate Practice" Studied by California Group . . . Convention Attendance Analyzed (Page 126) . . . Schmelzer Heads Md.-D.C. Association . . . Lueth Is President Elect in Nebraska

Legislation and Public Education Featured at California Meeting

SAN FRANCISCO.—The Association of California Hospitals held its midyear membership meeting last month in Santa Barbara with a registration of 226 administrators, representing Catholic, proprietary, voluntary and county and state institutions throughout the state. The program featured two major association interests—legislation and better public understanding of hospital economics and problems.

The conference opened with a summary of association activities during the last year by President Leroy R. Bruce of Los Angeles. Attention was then focused on legal problems confronting hospital administrators in California in connection with the 1949 session of the California state legislature, with association attorney Howard Burrell and the Rt. Rev. Msgr. Thomas J. O'Dwyer, chairman of the council on legislation, as the speakers.

A chief concern in the field of legislation revolves around the issue of what constitutes corporate practice of medicine, and progress was reported in working out model agreements on the employment of pathologists and radiologists —a joint project of the council and the California Medical Association—without violating the state law governing corporate practice of medicine.

At a luncheon meeting for administrators of public hospitals, J. Roy Holland, director of research for the California Taxpayers' Association, stated that the cumulative burden of all taxes, state, federal, county and municipal, and the increase in current patient costs for private hospitalization had resulted in an increased demand for public hospitalization. He suggested that public hospitals should hold to rigid admission policies and a realistic collection policy. Patients who are capable of paying their way in public hospitals should meet the costs of their care, he stated.

At another session, the members delved deeply into the subject of public understanding of hospital problems and better press relations. Thomas P. Langdon, chairman of the council on public education, presided over the meeting. Key speaker was Fred Glover, director of information at Stanford University, who advised administrators that the two steps necessary for obtaining the cooperation of newspapers were to cooperate with them and to educate them on hospital practices. He urged the enlightening of newspaper men on the restrictions placed upon hospital adminstrators by law and by circumstances. One of the main things, he explained, is to impress upon newspapers that the patients are the doctors' patients, not the hospital's, that a doctor can lose his license to practice because of violation of the confidential doctor-patient relationship, and that his malpractice insurance does not cover him where he oversteps the rules. Similarly, Mr. Glover commented, it is necessary to educate the hospital staff on the rules of the newspaper.

Ritz H. Heerman, administrator of the California Hospital at Los Angeles, emphasized that the hospital is usually to blame for the unsympathetic attitude of the public, simply because the public is never made aware of what actually constitutes hospital service, and of its nonprofit status. The public should be told the number of employes required to operate a hospital, he stressed, the amount of pay roll in the total cost of operating a hospital, the function of all the classifications of employes, and the rate structure in hospitals, with special emphasis on the fact that many hospital rates are below the cost of the services.

In one of the administrative sessions, Daniel M. Brown, Lodi Memorial Hospital, discussed labor-saving studies as a means of reducing pay roll costs. Teamwork is essential in a good hospital, and all the renovations and mechanical devices in the world cannot supplant its effectiveness in producing streamlined operation, he warned. An easy labor-saving device is to select the right type of worker, give him thorough orientation in his work, maintain a healthy interest in him and get the most out of his capacities and interests.

Stating that the incidence of accidents is startingly high—in some hospitals as much as one accident per patient or employe every day and a half for twenty-one months — Orville N. Booth, St. Francis Hospital, pointed out that this is a subject of vital concern to the administrator from the standpoints of good administration, economics and public relations. Steps to ensure a minimum of accidents are the formulation of a definite, clear set of rules to be circulated to every department, regular reviewing of these rules, and proper handling of the incident when an accident does occur, he advised. Responsibility in reviewing accidents and injuries is with the administrator, Mr. Booth said.

$1,350,000 Project

LOWELL, MASS. — Lowell General Hospital here will begin a $1,350,000 construction project in January, the hospital has announced. The new construction will include a nurses' home and a maternity and pediatric building, it was explained.

Hospital trustees have voted $350,000, and a public subscription campaign obtained $1,000,000 in the first public appeal for funds ever made by the hospital, which was founded in 1890.

YES, SHAW SOLUTIONS ARE THE BEST WE'VE EVER USED!

MY REASONS? WELL, HERE ARE A FEW—

"CLOSED DIAPHRAGM—Sterility Safe to the second we need it. Combines the advantages of the conventional 2 hole stopper and glass airway with the safety of a sealed diaphragm."

"CONVENIENT BOTTLE SIZE—A nurse can get her hand around its graceful shape."

"INDIVIDUAL LABEL COLOR—Every popular SHAW Solution has its own label color. Prevents mistakes when we're in a hurry."

"STURDY EQUIPMENT—Nothing jerry-built about Hospital Liquids disposable equipment. It looks, acts, and feels permanent and safe."

"SIMPLE TO USE—Ten seconds and you're ready for venipuncture."

"NO MESSY GLYCERINE TO WIPE AWAY—I never did like the chore of wiping sticky lubricant off a stopper top. It's no task with a SHAW Solution. A swift pass with your alcohol swab and you have all the lubrication you need."

Of course, we agree with everything the young lady has to say. And there are a lot more interesting and important advantages that we'd like to show you. Everything fourteen years of liter-solution experience has taught us is invisibly packed in your bottle of SHAW Solution—YOUR guarantee of QUALITY and SAFETY!

A Hospital Liquids man is as near as your phone. Phone or write us for a demonstration now!

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NEWS...

Change Name of Maryland-D.C. Association to Include Delaware

WASHINGTON, D. C.—Leo G. Schmelzer, administrator of George Washington University Hospital here, was named president-elect of the Maryland-District of Columbia Hospital Association during the eighth annual conference last month. Mr. Schmelzer will succeed Benjamin W. Wright, Memorial Hospital, Cumberland, Md., who became president during the conference.

Joseph G. Norby, president of the American Hospital Association, told the conference that the association will ask Congress for a law providing federal grants to states for medical care of indigent patients. Mr. Norby emphasized that a desirable law will provide for state rather than federal control of the distribution of funds.

Efforts to increase rates paid to hospitals by local governmental agencies responsible for charity cases were described by Dr. Edwin L. Crosby of Johns Hopkins Hospital and Harvey H. Weiss of Mount Sinai Hospital, Baltimore. Public officials in Maryland are aware of the hospital's financial problem in connection with indigent care and are interested in improving the situation, the speakers reported. However, it was pointed out, hospitals must do their share by providing accurate and complete information on the cost of these services.

In a session on hospital planning, Dr. A. J. Hockett of Wilmington General Hospital, Wilmington, Del., discussed the necessity for budgeting the personnel needs of each hospital department as an essential of proper architectural planning. The specific number of employes in each area and the nature of the duties to be performed are important determinants in planning, Dr. Hockett said. He described the organization of a service and maintenance department in one hospital, pointing out that a substantial reduction in the number of employes needed and consequently in departmental costs was possible when the department was properly studied and organized.

Several speakers and discussants in the session on hospital planning emphasized the importance of calling department heads into consultation with the administrator and architect to make certain that all departmental needs are adequately provided for in the plans.

Patient comfort rather than hospital tradition or convenience should be the aim of the daily program in the nursing department, Constance Long, director of nursing for the Hospital Division of the U.S. Public Health Service, stated in a discussion of current nursing problems. Miss Long stressed the need for better planning of nursing routines, including especially the assignment to auxiliary personnel of duties not requiring professional training.

Miss Long said that the planning function is an important responsibility of the nurse executive. She warned against diverting the major portion of the top nursing executive's time and attention to nursing school problems with resultant neglect of the first responsibility—nursing service to patients. Nurse executives should participate in top level personnel planning and policy making, Miss Long said.

Dr. Wetherbee Fort of Baltimore said many changes were needed in nursing organization plans in order to overcome present difficulties in the profession. Among other things, he recommended elimination of age limits for admission to nursing schools and the provision of old age security benefits for nurses; increased opportunities for recreation for student and graduate nurses; provision of city, county and state scholarships for nursing students; reduction of basic nurses' training to a two-year program with provision for a third year of specialized training for qualified students, and the organization of refresher courses for graduate nurses.

The conference passed a resolution changing the name of the association to the Maryland-Delaware-District of Columbia Hospital Association and extending an invitation to all Delaware hospitals to become association members.

In addition to Mr. Schmelzer and Mr. Wright, officers elected during the conference were: first vice president, Dr. M. A. Tarumianz, Delaware State Hospital, Farnhurst, Del.; second vice president, Sister Veronica, Mercy Hospital, Baltimore; third vice president, Deaconess Margaret S. Bechtol, Episcopal Eye, Ear and Throat Hospital, Washington, D.C.; secretary and treasurer, Richard R. Griffith, West Baltimore General Hospital, Baltimore; trustees, Brady J. Dayton, Salisbury, Md., James F. McCloskey, Wilmington, Del., J. G. Capossela, past president, Washington, D.C.

University of Pennsylvania to Operate Episcopal Hospital, Stassen Says

PHILADELPHIA.—The University of Pennsylvania and the Episcopal Hospital are entering into an agreement under which the university will operate the Episcopal Hospital at its present location, it was announced last month by Harold E. Stassen, president of the university, and Laurence H. Eldredge, president of the Episcopal Hospital.

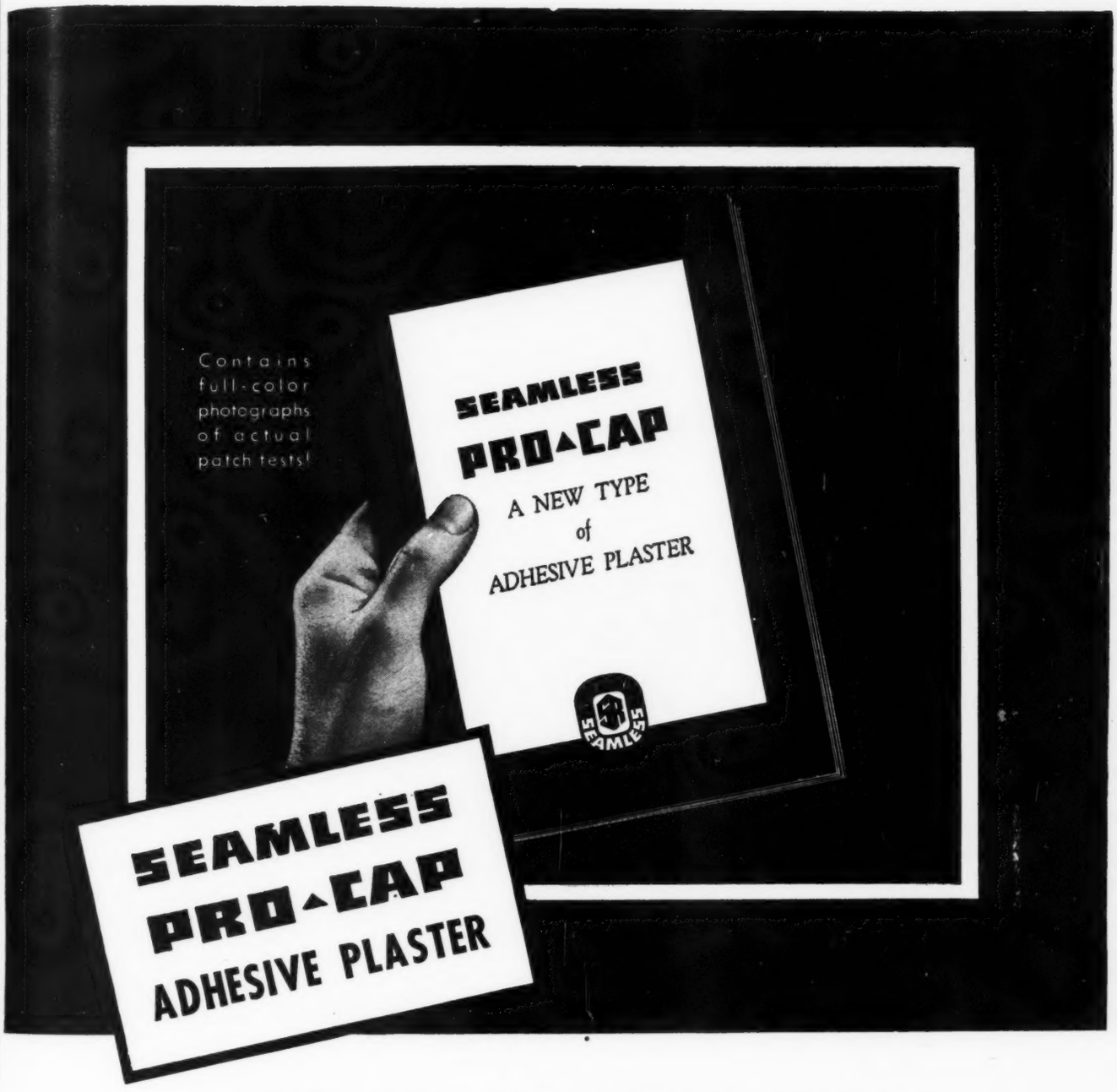
Under the agreement the hospital, which was founded in 1851, will be operated as one of the university hospitals, it was explained. In addition to continuing the hospital's activities, the university will augment the medical staff. Present members of the Episcopal Hospital staff will retain staff privileges at the hospital, the announcement said. Another step to be taken will be the formation of an advisory committee of representative citizens from the neighborhood the hospital serves. This committee will be nonsectarian.

It is the purpose of the new agreement to provide immediately even better hospital service than is at present obtainable in the neighborhood in which the Episcopal Hospital is located, according to the joint statement from the hospital and the university. The agreement also ensures a helpful basis for long-range planning by stipulating that thorough studies of the needs of the neighborhood shall be made by the university and the hospital in conjunction with the proposed advisory committee and the citizens' conference on hospital capital requirements in Philadelphia, the statement declared.

Wesley Memorial Hospital Given Teaching Instrument

CHICAGO. — A rare teaching instrument through which ten students can view the same microscopic image simultaneously has been presented to Wesley Memorial Hospital here, Ralph M. Hueston, superintendent, announced last month. The instrument is known as a scopicon, Mr. Hueston said.

In using the scopicon, students sit at a special viewing table equipped with ten removable viewing hoods. Built-in pointers are provided at convenient intervals so that the operator, or any of the observers, may point out significant details on an image projected for group discussion. The scopicon will be used for the simultaneous study of tumor tissues and for staff consultation.



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FINEST QUALITY SINCE 1877

NEWS...

Court Declares Hospital Authority Act Unconstitutional

SPRINGFIELD, ILL.—The 1947 Hospital Authority Act was declared unconstitutional by the Supreme Court of Illinois in a ruling here last month. The court ruled on the validity of the hospital authority at Henry, Ill. A previous decision held invalid the hospital authority at Sterling, Ill.

The law, which made possible the creation of local hospital authorities with taxing privileges and under which several hospital projects had been planned to take advantage of federal aid under Public Law 725, was declared unconstitutional because it permitted rural residents of the hospital authority areas separate referendums in connection with establishment of the authorities. The court said this provision constituted special legislation giving rural voters rights which were not extended to those in cities.

New York Hospitals Merge

NEW YORK.—Consolidation of the Post-Graduate Medical School and Hospital into the New York University-Bellevue Medical Center was completed here last month with the signing of a merger agreement. Chancellor Harry Woodburn Chase announced that the university had organized a new post-graduate unit to be known as the Post-Graduate Medical School of New York University-Bellevue Medical Center.

Under the consolidation agreement, properties of the former Post-Graduate Medical School will become united with those of the medical center, including the Post-Graduate Hospital which will now be operated as a medical center unit.

Presbyterian Hospital Elects Snyder to Board of Trustees

Dr. Franklyn Bliss Snyder was elected to the board of managers of Presbyterian Hospital of Chicago last month. Dr. Snyder who has been president of Northwestern University for the last ten years will retire from the university position next summer. His election to the hospital board was said to be "in anticipation of his assumption of the presidency of the hospital after his retirement as president of Northwestern University," a newspaper report said. It was reported that the hospital presidency will become a full-time job with a salary when Dr. Snyder takes over.

Harold C. Lueth Named President-Elect of Nebraska Hospital Assembly

LINCOLN, NEB.—Dr. Harold C. Lueth, dean of the University of Nebraska Medical School and administrator of the university's hospital at Omaha, was named president-elect of the Nebraska Hospital Assembly during its twelfth annual meeting here last month. Donald W. Duncan, St. Elizabeth's Hospital, Lincoln, succeeded Rev. Edwin C. McDade, Bryan Memorial Hospital, Lincoln, as president during the assembly.

In one of the outstanding papers presented during the assembly, Rev. B. O. Lyle of Nebraska Methodist Hospital, Omaha, said that hospital people need to be reminded that hospital care is a Christian service and that hospital employes must be inspired to serve in a humane, Christian spirit. All hospital personnel should take part in educational programs aimed at creating a better understanding of the physical and psychological needs of hospital patients, Rev. Lyle stated. He added that the inspiration to serve in the proper spirit is particularly necessary for nursing personnel.

New President Donald Duncan President-Elect Harold Lueth and Retiring President E. C. McDade of the Nebraska hospital group.

The Rev. Mr. Lyle's remarks were supported by Everett W. Jones, vice president of The Modern Hospital Publishing Company, Inc., who declared that the hospital should be distinguished by what he called a "golden rule atmosphere" providing mental and spiritual reassurance for the worried patient and his family. It is the administrator's job to create this atmosphere, Mr. Jones said, and it can only be found in hospitals where the employes' needs for economic security and job satisfaction are adequately understood and met.

This view was echoed by a nurse participant in the program, Helen Carlson, director of nurses at Dodge County Community Hospital, Fremont, who acknowledged that some nurses put too much emphasis on pay and not enough on good patient care. The good nurse recognizes the financial problems hospitals are facing today, Miss Carlson said, and is loyal to her hospital.

Speakers and discussants stressed the need for organization of practical nurse training programs to provide auxiliary personnel to meet hospital needs. Dr. Lueth urged hospitals to explore the possibility of organizing practical nurse training programs in cooperation with local boards of education.

In one of the major talks on the two-day program, Albert V. Whitehall, secretary of the American Hospital Association's council on government relations and chief of the association's Washington staff, said that solution of the problem presented by inadequate payment for indigents is the essential first step in working out the financial future of the voluntary hospitals. Mr. Whitehall declared that adoption of the federal reimbursable cost formula by local, state and federal agencies accepting responsibility for hospital care would meet the major need of most hospitals.

Mr. Whitehall also urged vigorous promotion of Blue Cross and Blue Shield prepayment plans to lift the nation's number of American families out of the "medical indigent" class.

Mr. Whitehall said the association was urging administrators of member hospitals to arrange meetings with their congressmen and senators for discussion of hospital financial problems before Congress opens next year.

TRUSTEES, NEWSPAPERS INTERESTED

At a meeting devoted to the interests of hospital trustees, Walter S. Ross, trustee and secretary of the Clay Center Municipal Hospital of Clay Center, Kan., urged attendance of hospital trustees at state, regional and national hospital conventions. The trustee must know what hospital services are and what they cost, Mr. Ross said, and must be prepared with adequate facts and figures to demonstrate the hospital's value to the community. He described how government officials in his com-

(*Continued on Page* 150.)

NEWS...

1540 Administrators Attended 50th Convention, A.H.A. Analysis Indicates

CHICAGO.—Total registration at the fiftieth anniversary convention of the American Hospital Association at Atlantic City last September was 6340, the association reported in an analysis of convention attendance released to exhibitors last month.

The total attendance was divided into three principal classifications, it was explained. Largest group was "hospital, public health and planning agencies" with 4502 representatives. Exhibitors and manufacturers' representatives totaled 1787, and there were fifty-one "visitors, guests and program participants," the report said.

In a further breakdown, it was reported that 1540 hospital administrators were registered at the convention. Other hospital representatives were: department heads, 512; general personnel, 549; nurse anesthetists, 260; medical record librarians, 25; auxiliary groups, 365; hospital and medical care plans, 44; architects 67, consultants, 81; state planning agencies 110, and "other related" hospital representatives, 536.

Manufacturers and dealers had 1610 representatives in convention exhibits, the analysis indicated. Nonexhibiting dealers totaled 159, and prospective exhibitors, 18, the report said. Public health organizations were represented by 413 registrants.

Buick Dealers Present Hospital With $50,000

FLINT, MICH.—The Flint Women's Hospital was the beneficiary of an unusual gift last month when midwestern automobile dealers presented the hospital with a check for $50,000 honoring Harlow H. Curtice, general manager of the Buick Motor Company, and W. F. Hufstader, Buick sales manager. Mr. Curtice and Mr. Hufstader were both leaving Flint to assume other responsibilities with the General Motors organization and the gift was made in recognition of their service in the last fifteen years.

Explaining why the group selected the hospital as beneficiary of the memorial gift, a spokesman said, "No physical thing we can give you can begin to make plain how much we value what you have given us in the last fifteen years. We know that almost as strong as your interest in Buick is your interest in the city of Flint and such institutions as the Women's Hospital."

Hospital Must Find New Income or Close Doors

ALEXANDRIA, VA.—The Alexandria Hospital here will be forced to close unless new sources of income can be made available, directors of the hospital announced publicly last month following a meeting at which the directors asked the city council for support. Estimated operating deficit for the hospital in 1948 was $70,000 the statement said. A fund of $185,000 obtained in a fund raising drive during the year was consumed in meeting back obligations, it was stated.

Explaining the hospital's financial situation, Van C. Adams, administrator, said that 33 per cent of all hospital patients are unable to pay the full hospital bill and another 26 per cent are cared for at less than cost under group hospitalization contracts.

NEWS...

Opens X-Ray Therapy Unit

WAUKESHA, WIS.—Waukesha Memorial Hospital here has recently opened a deep x-ray therapy department, Franklin D. Carr, administrator of the hospital, announced last month. The chief item of the new department is a 220,000 volt x-ray machine of the latest type, Mr. Carr said. The new installation makes x-ray treatment for cancer available for the first time in Waukesha County thus saving time and trouble for cancer victims.

Approves P.H.S. Grants for Scientific Research

WASHINGTON, D.C.—Surgeon General Leonard A. Scheele of the U.S. Public Health Service has approved thirty-seven grants of funds totaling $455,715 for research in medical and related scientific fields, it was announced here last month. The grants approved were recommended by the National Advisory Health Council at a recent meeting.

Dr. Scheele explained that the grants will help to finance the continuation of research projects already under way at institutions in fifteen states. The studies are designed to provide new scientific data on a wide variety of human ailments. Several of the grants will continue research into the use of streptomycin in tuberculosis, which is offering promising results in some types of the disease. Another will finance further experimentation into a new surgical technic for combating coronary thrombosis, it was explained.

The grants approved by the surgeon general were as follows:

INSTITUTE	AMOUNT
California Institute of Technology, Pasadena	$ 6,069
University of California, Berkeley	2,635
University of Southern California, Los Angeles	540
University of Colorado Medical Center, Boulder	3,105
Children's Hospital, Washington, D.C.	4,025
University of Georgia, School of Medicine, Athens	8,333
Georgia Institute of Technology, Atlanta	10,565
University of Illinois, College of Medicine, Chicago	6,580
University of Chicago	16,362
Northwestern University Medical School, Chicago	48,600
State University of Iowa, Iowa City	2,300
Tulane University, New Orleans	16,902
Johns Hopkins University, Baltimore	2,700
Harvard Medical School	4,674
President and Fellows, Harvard College, Boston	21,600
Channing Home for Tuberculosis, Boston	13,878
Mineral Springs Sanatorium, Cannon Falls, Minn.	5,300
University of Kansas City, School of Dentistry, Kansas City	4,266
Washington University, School of Medicine, St. Louis	6,480
Duke University, Durham, N.C.	36,104
University of Buffalo, Buffalo, N.Y.	14,485
New York University	39,896
Mount Sinai Hospital, New York	2,640
Albany Medical College, Albany, N.Y.	4,500
University of Rochester, Rochester, N.Y.	20,088
Columbia University College of Physicians and Surgeons, New York	19,440
Cleveland Clinic Foundation, Cleveland	23,750
Ohio State University, College of Medicine, Columbus	2,000
Ohio State University, Columbus	14,875
Western Reserve University, Cleveland	27,884
University of Oklahoma, School of Medicine, Oklahoma City	11,602
Esmond R. Long, Care of National Tuberculosis Association, Wayne, Pa.	64,620

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NEWS...

G.E. Adopts Hospital Insurance Plan for Pensioned Employes

SCHENECTADY, N.Y. — The General Electric company has adopted a hospitalization insurance plan providing cost-free benefits for certain eligible pensioned employes, Charles E. Wilson, president, announced last month. The new plan will provide benefits for more than 7500 retired employes and will afford similar benefits for all other eligible employes retiring during the life of the plan, it was explained.

Discussing the duration and purpose of the experimental plan, Mr. Wilson said, "It is believed that the assets of the pensioners hospitalization fund will be sufficient to operate the plan for a few years. It is hoped that the experience thus gained will enable the continuance of similar protection through mutual benefit associations and insured plans."

This is among the first attempts that have been made to gather data concerning hospitalization insurance for persons during their retirement years.

The plan provides a $5 allowance to be applied toward payment of the room charge for each day an eligible pensioner is confined as a bed patient in a legally constituted hospital. A grant of $25 for special hospital services is applicable to each separate admission to a hospital, even though the pensioner may not be a bed patient. Total maximum benefits are limited to $250 for any one pensioner during his lifetime.

Benefits under the plan are not obtainable where hospitalization is available free of charge, or for any accident or sickness entitling benefits under any workmen's compensation law, occupational disease law, or similar statutes. Neither can they be used for payment of charges for doctors, surgeons or nurses or other charges not made by the hospital.

Benefits are payable directly to the hospital rendering the services, to the claimant or to any person the pension board may determine is best fitted to administer the benefits to such pensioner. Payments will be made on a reimbursement basis for charges actually billed by the hospital.

General Electric pensioners are scattered throughout the world, it was stated. Forty-two states and the District of Columbia are listed on the domestic roster of pensioners.

NEWS...

Upstate New York Area Reports on Health Needs of 75,000 Persons

ALFRED, N.Y.—Basic questions concerning the health of 75,000 persons in this upstate area of New York State were covered in a survey made by Alfred University, it was announced here last month.

The survey report, which describes general health conditions and hospital services, is being distributed to doctors, hospitals and health associations in a three-county area including sections of Allegany, Steuben and Livingston counties, it was explained to the press.

Written by Dr. Roland L. Warren, head of the sociology department, the study lists as some of the important health issues facing residents:

1. The meeting of conditions necessary to obtain maximum state and federal aid for hospitals.

2. The willingness to pay higher county taxes to provide facilities for the care of chronically ill and aged persons.

3. The attraction to the area of needed specialists, dentists and registered nurses.

4. The improvement of public health services.

Among the outstanding facts about area hospitals revealed in the report were these:

1. Six general hospitals in the area have a total of 335 beds, or 4.48 per 1000 population. This is slightly below the five beds per 1000 recommended by the council of Rochester regional hospitals.

2. Total of admissions to all area hospitals during 1947 was 14,641, or slightly more than one admission for every six persons in the area.

3. Only hospital in the area with a nursing school is St. James at Hornell In addition, however, Alfred University has a school of nursing on the college level.

4. All area hospitals except Wayland store blood from the Red Cross blood bank. Wayland gets blood for transfusions through the Dansville General Hospital.

5. The ratio of total assets to beds varies from $206.33 in Wayland to $6,852.44 per bed in Wellsville.

The report shows that the following facilities, not now available, are needed by area hospitals and could be supported by area people:

1. At least fifty-eight new beds in the Hornell area alone.

2. Expanded facilities for training nurses.

3. A diagnostic clinic for cancer.

4. A physical therapy department, with a registered physical therapist, at St. James Hospital.

Plans for expansion in the area include:

1. Reorganization of the floor plan at Bath Memorial for greater efficiency and to provide space for new departments.

2. An increase of twenty or more beds at Dansville General and the possibility of including public health service.

3. A new delivery room, operating room, central supply room, sprinkler system, and other improvements at Bethesda Hospital.

4. A new south wing at St. James to increase its bed capacity from 102 to 145.

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NEWS...

Urges V.A. to Plan Hospital Program in Accord With Community Needs

NEW YORK. — A recommendation that the Veterans Administration plan its hospital program with some regard for local community resources is featured in the annual report of the Hospital Council of Greater New York, released last month by Norman S. Goetz, president. Hospital facilities provided by the Veterans Administration should be coordinated with those of the local community, the council report stated.

In contrast to the lack of coordination with local community planning evidenced by the program of the Veterans Administration, Mr. Goetz cited the Hospital Survey and Construction Act. "The council is gratified," he stated, "that its master plan for hospitals and related facilities for New York City has been included without major changes in the state plan of the Joint Hospital Survey and Planning Commission of New York State. New York City is thus assured of a plan developed by a voluntary agency, adopted by the state agency, and approved by the federal government. In many ways the council has set a pattern by which voluntary agencies may guide and assist in the execution of federal and state laws. In these days when so many people are fearful that the voluntary system of hospitals may be encroached upon, it is significant that state and federal authorities are anxious to avail themselves of the services of a voluntary agency such as the hospital council," the report declared.

"It will be recalled that the master plan indicates that a total of only eighty general hospitals, if of proper size and well located, would best serve the needs of New York City," the report continued. "At the present time there exist approximately 145 general care hospitals. Because of our desire to make use of all available resources, it may not be possible to reduce and redistribute the facilities to a total of eighty. However, the participating hospitals form the nucleus of the general hospitals which the council considers essential for the public welfare. It is expected that the community's interest in and support of the participating hospitals will increase as progress is made under the master plan."

When Whims and Fancies Obstruct Good Nutrition

Often perverted food attitudes and abnormal outlooks regarding foods and nutrition interfere with adequacy in dietary intake or are responsible for nutritionally improper eating habits. Accordingly, excessive amounts of foods one-sided in nutrient content are consumed, or more desirable foods are avoided, to the detriment of the nutritional health.

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PROTEIN	32.1 Gm.	VITAMIN B_1	1.16 mg.
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CARBOHYDRATE	64.8 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.50 mg.

***Based on average reported values for milk.**

NEWS...

New York Hospital Inaugurates Forty-Hour Week for Nursing Staff

NEW YORK. — A forty-hour week for nurses went into effect last month at New York Hospital, it was announced by Dr. Stanhope Bayne-Jones, president of the administrative board of the New York Hospital-Cornell Medical Center, and Laurence G. Payson, acting director of the hospital. The forty-hour week provided immediate salary increases for all nurses at the hospital, it was explained. Under the new schedule, salaries for the forty-hour week range from $200 to $235 monthly for general staff nurses, from $210 to $245 for assistant head nurses and from $230 to $260 for head nurses, the announcement said.

This change in the basic salary arrangement is part of a development of new nursing policy at the New York Hospital, Dr. Bayne-Jones and Mr. Payson said. A major consideration of the program is to relieve nurses of non-nursing and housekeeping duties to free their time for more direct care of the patient, it was added.

"The separation of nursing and non-nursing duties," said Dr. Bayne-Jones, "is a step which must be taken if patients are to benefit from the great strides being made today in medicine. The nurse today must be more highly trained and more versatile than ever before, and she can receive the greatest satisfaction by using her skills in the best possible bedside care."

Foreign Visitors Study Our Hospitals

A number of foreign delegations and individuals have been visiting in this country, studying American hospitals. Rotterdam is represented by Dr. A. J. V.d.Schaar, medical director; Ir. A. Viergever, chief architect of public works; H. Valk, economic director, and J. A. C. Tillema, director of public works. Among other investigations the Rotterdam group is studying the double corridor plan as exemplified in St. Luke's Hospital, Bethlehem, Pa., and the Alexandria Hospital, Alexandria, Va.

From Nassau, the Bahamas, has come Harold Christie, member of parliament and chairman of the hospital committee for the new Bahamas General Hospital. Other recent visitors have been H. F. Billimoria, chief architect of the public works department of Colombo, Ceylon, and Dr. William E. Braisted of the Chin Li Hospital, Kwangtung, China. This latter institution is operated by the American Baptist Foreign Mission Society and Dr. Braisted is here studying hospital design and layout in the interest of a new 200 bed unit for his institution.

Guatemala likewise has been represented by Oscar Barahona, director of Social Security; Dr. Salvador Hernandez, deputy commissioner of public health, and Oscar Martinez and Juan Lizarralde, architects and engineers. As has been already announced in these columns, Guatemala is engaged in a nationwide program for health and hospital development sponsored by the Institute, which will ultimately involve the construction of some sixty-five hospitals. Neergaard & Craig of New York City are serving as consultants on this project.

NEWS...

Student Nurse Recruitment in New York Campaign Surpasses Goal Set

NEW YORK. — The recent student nurse recruitment campaign of the Citizens' Committee on Hospital Careers surpassed its goal, Louis Schenkweiler, president of the Greater New York Hospital Association, announced last month, releasing the results of a survey of 96 voluntary and 23 municipal hospitals in the metropolitan area.

"We are deeply grateful to Mayor O'Dwyer, Helen Hayes, chairman, and Mr. Anson Lowitz, vice chairman, for their splendid leadership in enlisting the cooperation of many prominent civic and business leaders, and representatives of medical, health, hospital, educational, nursing and welfare agencies in our campaign," said Mr. Schenkweiler. "Special praise is owed to Mr. Lowitz, coordinator for both the local and national campaigns, and to leaders in the newspaper, radio, motion picture and advertising field who contributed so generously of their time and talents to convey the message of the hospitals."

Beginning its activities last May, the citizens' committee set a goal of 1400 new student nurses for September classes in the thirty-seven registered and eight practical nursing schools of the association. According to the survey, 1829 new students have been accepted, 1606 in registered and 223 in practical nursing schools.

As a result of the local campaign, which was carried on simultaneously with the national campaign of the American Hospital Association and the Advertising Council, thirty of thirty-six registered and five of eight practical nursing schools in New York had no vacancies in their September entering classes. Twenty-six registered nursing schools accepted in September 1948 a total of 309 more new students than they admitted in 1947, three schools accepted the same number as in 1947, and seven schools accepted forty-two fewer than in 1947. Five practical nursing schools accepted in September 1948 a total of twenty-six more new students than they admitted in 1947, one school accepted the same number as in 1947, and two schools accepted thirteen fewer than in 1947.

According to Mr. Schenkweiler, the upward trend of nurse recruitment has brought the total local nursing school enrollment to a level which compares favorably with that of the war years, when wartime motivation and tuition paid by the government brought student nurse enrollment to its highest peak.

Cancer Institute Affiliates With Wayne University

DETROIT.—Formal affiliation of the Detroit Institute for Cancer Research with the Wayne University College of Medicine was approved by the Detroit Board of Education last month when the board of trustees of the institute and the college of medicine's committee on administration adopted a resolution recognizing that the ultimate interests of the community in the attack on the problem of cancer would be served best by amalgamation of the forces of the institute and the university.

Details of the affiliation include the provision that appointments to the

scientific staff of the institute will be made upon recommendation of the scientific director when such recommendations bear the endorsement of the faculty of Wayne University. Officials of the institute and the university expect that the affiliation will bring national support to both on a wider basis than would be possible without the combined resources. Each agency will, in addition, have greater resources in terms of personnel and research technics upon which to draw.

University of Houston Offers Correspondence Course in Hospital Accounting

HOUSTON, TEX. — The University of Houston is offering a correspondence course in hospital accounting and office procedure, a university announcement said last month. The course is in eighteen assignments and carries with it four hours of college credit. It is sponsored by the Texas Association of Hospital Accountants and has been officially endorsed by the Texas Hospital Association.

Dr. J. Marvin Sipe is director of the course. Dr. Sipe is head of the accounting department of the University of Houston and has participated in meetings of the Texas Association of Hospital Accountants, including the basic accounting institute held in Houston some time ago.

Although the course has been offered for only a few months, inquiries from 200 hospitals have been received.

5000 Persons Attend A.M.A. Interim Session

ST. LOUIS. — An estimated 5000 persons, including physicians, military personnel, technical and scientific exhibitors, and their families, attended the interim session of the American Medical Association here November 30 to December 3. The interim session, which is held between annual A.M.A. sessions, is devoted primarily to the general practitioner, the family doctor whose practice makes up a major portion of all medical service.

County medical society officers attended a "Grass Roots Conference" to discuss medical problems of various localities, voluntary health insurance plans, hospitalization plans, and improvement in medical facilities, rural health activities, and activities of the A.M.A. bureaus and councils.

Among the speakers appearing before the conference were R/Adm. Joel T. Boone, (MC), U.S. Navy, Washington, D.C.; Brig. Gen. George Armstrong, MC Deputy Surgeon General U.S. Army, Washington, D.C.; Norvin C. Kiefer, Senior Surgeon, Office of the Surgeon General, U.S. Public Health Service, Washington, D.C.; Lewis Meriam, Washington, co-author of the Brookings Report, and Dr. Louis Bauer, Hempstead, N.Y., a member of the board of trustees of the A.M.A. and secretary of the World Medical Association.

Scientific sessions, scientific exhibits, technical exhibits, and sessions of the house of delegates were held in the municipal auditorium. In addition, television was shown continuously, under the sponsorship of St. Louis University School of Medicine and Washington University School of Medicine, and medical motion pictures were shown daily in the clinical presentation rooms adjoining the scientific exhibit.

Watch what happens WHEN DRAINAGE HITS A

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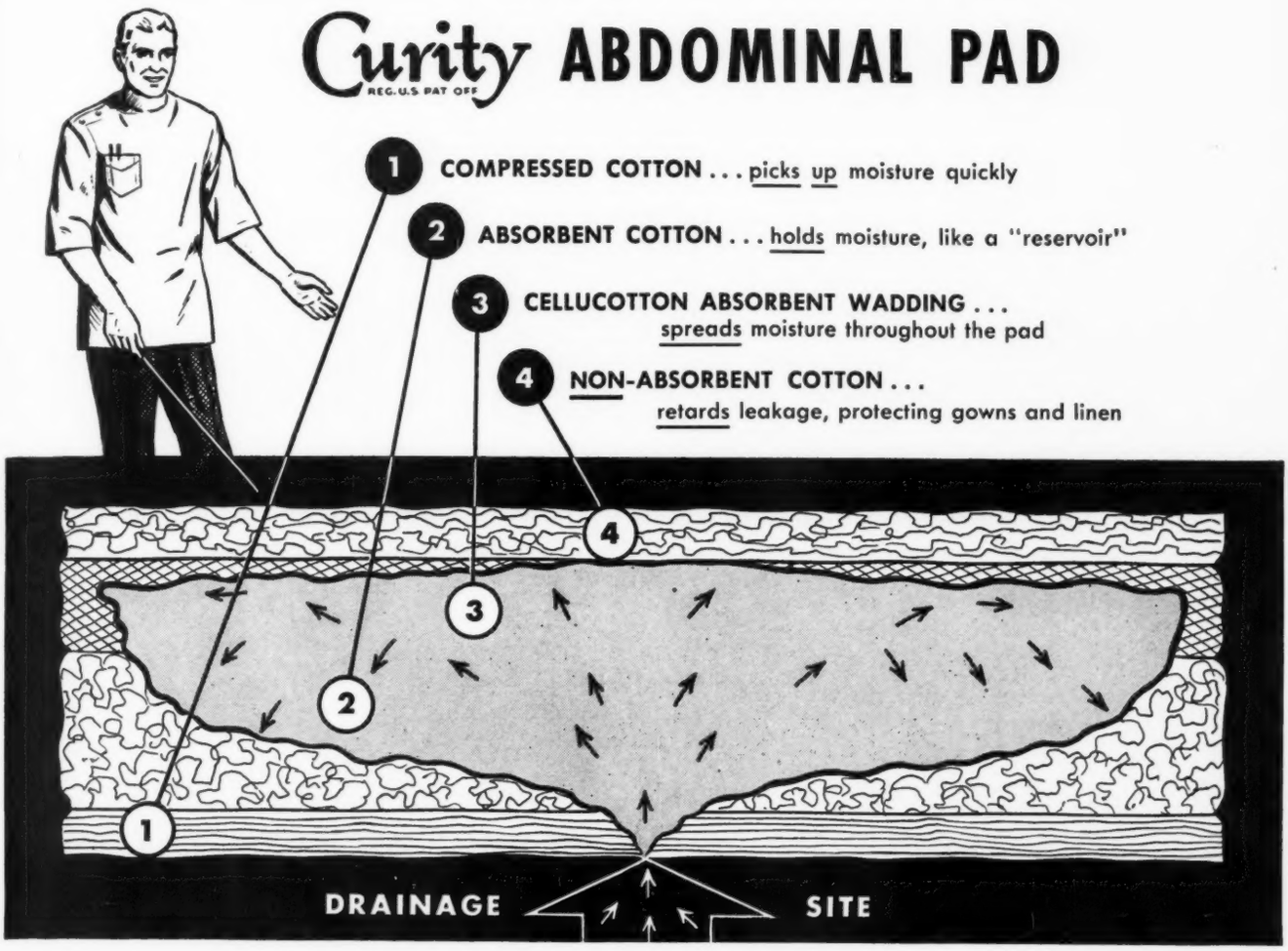

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NEWS...

Michael Reese Hospital Opens Chest X-Ray Center

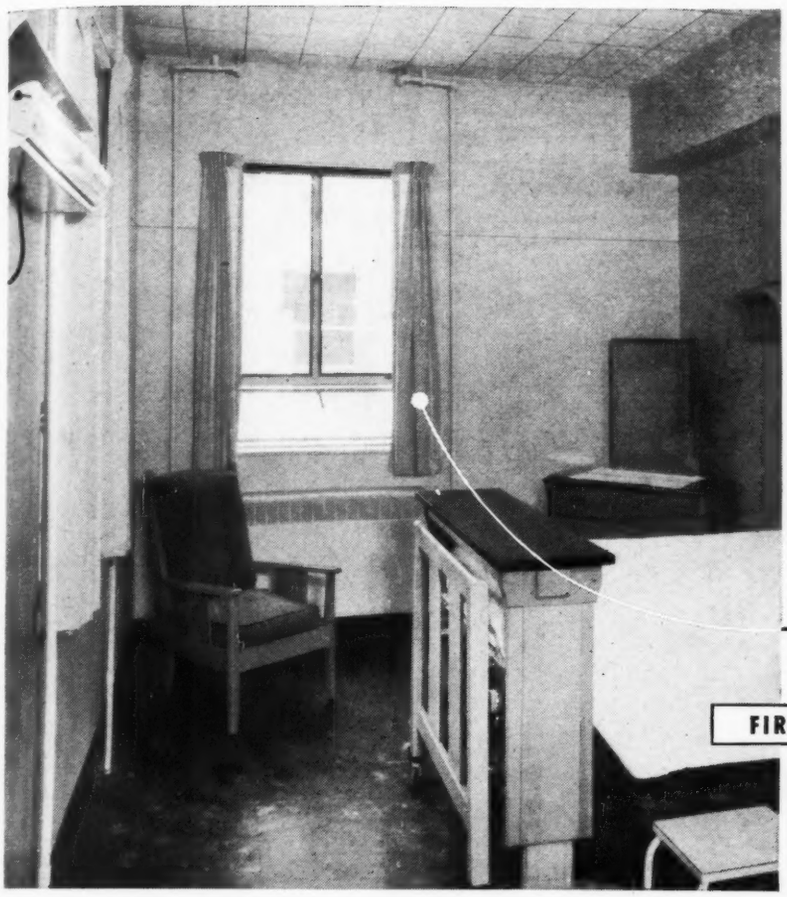
CHICAGO. — Dr. Herman N. Bundesen, president of the Chicago Board of Health, was among the city, state and federal public health officials officiating at the opening of the Michael Reese Hospital chest x-ray center here November 17. The opening of the new building, a permanent structure of the most recent design, launched the vast community health project which was formulated about two years ago, a hospital announcement said.

It is expected that when the center is operating at capacity it will examine approximately 100,000 people a year, the hospital stated. The x-ray examinations are free and take about one minute per person; mass x-ray equipment and technicians have been made available through the cooperation of the United States Public Health Service and the Illinois Department of Public Health, it was explained.

The combined chest service of Michael Reese and Winfield hospitals, directed by Dr. Edwin Levine, will coordinate the program, which will receive cooperation and aid from other public and private agencies. "Our program represents the modern idea that everyone should have a chest x-ray once a year," stated Dr. Levine. "It has been known for years that the only way tuberculosis and other diseases of the chest can be found at a reasonably early period is to examine people who have no suspicion that anything may be wrong with them.

"The Michael Reese Hospital chest x-ray center will be a new and important development in the public health field. It will be more than the customary case-finding x-ray project in that perhaps the most significant part of this permanent community health center associated with a general hospital will be that all the diseases discovered will be treated and that an attempt will be made to prevent any disease of the heart or lungs that seems imminent.

"Although the center will examine people from all parts of the city, we are going to concentrate our efforts on the area surrounding Michael Reese Hospital. This section, in which more than 100,000 people live, has one of the highest death rates for tuberculosis in the city. By examining every in-



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How Fencraft Windows Protect Patients

3 important ways

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SECOND They help protect health . . . by providing *controlled* fresh-air ventilation. Swing leaves of Casement and Combination Types reach out and guide fresh air into the room—wherever you want it. Open-in sill vents of the Projected and Combination Types flow air ceilingward, guarding patients against drafts.

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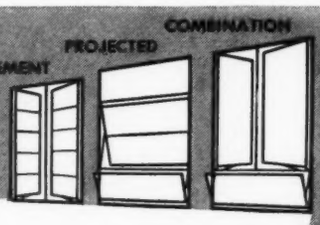

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habitant in this area we hope to obtain information that will be helpful in solving some of Chicago's greatest health problems."

Chicago Medical School Granted Full Approval

CHICAGO. — The American Medical Association and the Association of American Medical Colleges last week granted full approval to the Chicago Medical School. The recognition gives Chicago five approved medical schools, an equal number with New York City.

"The Chicago Medical School now offers an educational program that meets the standards for an approved medical school," the approval statement said. "Therefore, the school is now included on the list of approved medical colleges and hospitals of the A.M.A. and is admitted to membership in the A.A.M.C. This action applies to all students now enrolled in the regular four-year course at the school."

Established in 1912, Chicago Medical School was created from the merger of the Chicago Hospital College of Medicine and Jenner Medical School. It is chartered by the state of Illinois as a university on a nonprofit basis and is affiliated with Mount Sinai Hospital and other hospitals in Chicago.

Dr. John J. Sheinin, who was graduated from Northwestern University Medical School in 1932, is dean of the school, which has a staff of 250 and nearly 300 students.

Other approved medical schools in Chicago are those of the University of Chicago, Northwestern University, the University of Illinois, and the Stritch School of Medicine of Loyola University.

Recommend Licensing of Practical Nurses at Colorado Hospital Meeting

DENVER.—More than 100 members representing most of the hospitals in the state attended the twenty-fourth annual meeting of the Colorado Hospital Association here last month, Dr. Bertram B. Jaffa, executive secretary reported. After discussion of hospital and nursing licensure, members in a business session decided that the association should cooperate with nursing organizations to present a bill to the state legislature providing for the licensure of practical nurses. However, it was pointed out that the bill should be carefully drawn to assure adequate protection for nursing and hospital groups and for the public.

Walter G. Christie, administrator of Presbyterian Hospital of Denver, was named president-elect of the association. He will succeed Frank G. Palladino of the Community Hospital, Boulder, present president. Other officers elected were: vice president, Hubert W. Hughes, St. Anthony Hospital, Denver; treasurer, Sister Mary Thomas, Mercy Hospital, Denver; executive secretary, Dr. B. B. Jaffa, Denver; trustees, Roy R. Prangley, St. Luke's Hospital, Denver; Dr. James P. Dixon, Denver General Hospital; Louis Liswood, National Jewish Hospital, Denver; DeMoss Taliaferro, Children's Hospital, Denver; Roy R. Anderson, Presbyterian Hospital, Denver; the Rev. Allen H. Erb, Mennonite Hospital, La Junta; A.H.A. delegate, Dr. Herbert A. Black, Pueblo; alternate, Msgr. J. R. Mulroy, Denver.

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NEWS...

Make Improvements at Eye and Ear Infirmary

CHICAGO. — Physical improvements costing almost $100,000 are nearing completion at the Illinois Eye and Ear Infirmary here, according to the superintendent, Lester R. Gerber. The improvements have been made by the State Department of Public Welfare in order to make possible the handling of an increasing number of patients and to provide more nearly adequate facilities for an expanding teaching program, it was explained.

Mr. Gerber pointed out that the facilities previously were inadequate to care for the patient volume. More than 87,000 patient visits were made last year to the infirmary, which is staffed by the University of Illinois College of Medicine.

Recent improvements include a new suite of operating rooms, including two in the eye department and two in the ear-nose-throat department. New examination and treatment rooms have been added, and waiting rooms for patients have been separated from the space allotted for examination.

New additions also include the establishment of a laboratory for eye pathology and another for photography. Other improvements, including installation of a new elevator, have been made or now are being undertaken, Mr. Gerber stated.

Lay Cornerstone for Ewing Cancer Center

NEW YORK. — Cornerstone ceremonies for the 300 bed James Ewing Hospital for Cancer, which will be affiliated with the Memorial Cancer Center, were held here November 26 with Mayor William O'Dwyer as principal speaker. Dr. Edward M. Bernecker, commissioner of hospitals, presided and other speakers included Dr. C. P. Rhoads, director, and Reginald G. Coombe, president of the Memorial Hospital Center; Charles F. Kettering, member of the board of trustees of the Sloan-Kettering Institute, and Commissioner Frederick H. Zurmuhlen of the Department of Public Works, under whose jurisdiction the hospital is being constructed.

Construction costs of the city's new cancer hospital, which is expected to be completed late next year, will total $5,632,250. Ewing is the second municipal cancer hospital nearing comple-

tion. Construction of the Francis Delafield Hospital, which will be affiliated with the Columbia-Presbyterian Medical Center, was started last September 21.

The new hospital was named by the city as a memorial to the late Dr. James Ewing, eminent physician and pathologist, on recommendation of Commissioner Bernecker, "because of his long association with Memorial Hospital, his outstanding position in the field of cancer and his many contributions to the various hospitals of our department going back over many years."

Dr. Bernecker made the following statement in connection with the construction of James Ewing Hospital: "This new 300 bed hospital which will be an integral part of Memorial Cancer Center will provide much needed facilities for the treatment of long-term cancer patients in this city. We are fortunate indeed that an arrangement has been effected with Memorial whereby the medical and research staffs of this great cancer center will be available for city patients. This marks another forward step in which the best possible patient care, research, prevention and education are joined in the eventual hope of everyone for the conquest of cancer."

Medical Colleges and A.M.A. to Survey Programs of Medical Education

CHICAGO. — The Council on Medical Education and Hospitals of the American Medical Association and the Association of American Medical Colleges will sponsor a joint survey of medical education beginning Jan. 1, 1949, it was announced here last month.

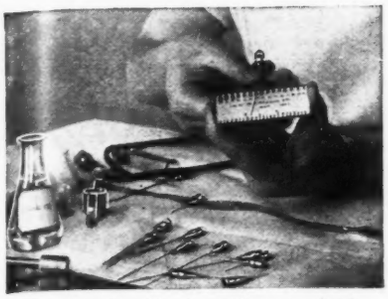
Members of the committee appointed to conduct the survey and publish a report of its finding are: chairman, Dr. Alan Valentine, president, University of Rochester, Rochester, N.Y.; Dr. Arthur C. Bachmeyer, associate dean, University of Chicago School of Medicine; Dr. Herman G. Weiskotten, dean, Syracuse University College of Medicine, Syracuse, N.Y.; Dr. Joseph C. Hinsey, dean, Cornell University Medical College, New York; Dr. Victor Johnson, director, Mayo Foundation for Medical Education and Research, Rochester, Minn.; Dr. Dean F. Smiley, secretary, Association of American Medical Colleges, and Dr. Donald G. Anderson, secretary, Council on Medical Education and Hospitals.

The committee announced that it had appointed Dr. John E. Deitrick of New York to be the full-time director of the survey. Dr. Deitrick is a graduate of Johns Hopkins University School of Medicine.

The committee stated that the objectives of the study are to evaluate present programs and determine future responsibilities of medical education in its broadest aspects for the purposes of:

1. Improving medical education better to meet the overall needs of the American people for the maintenance of the best standards of physical and mental health of all the people.
2. Assessing the degree to which medical schools are meeting the needs of the country for physicians.
3. Promoting the advancement of knowledge in the field of medical science.
4. Better informing the public concerning the nature, content and purposes of medical education.

HOW TO CARE FOR HYPODERMIC NEEDLES . . .

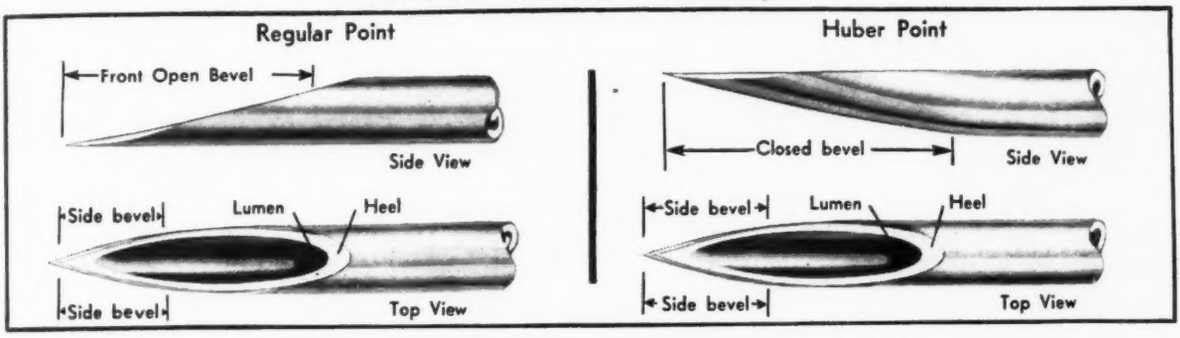


Gauging Needle size with a standard steel wire gauge

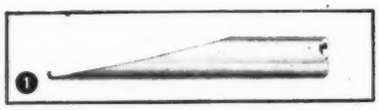
Testing strength of long Needle by flexing

Rinsing Needle with Alcohol and Ether

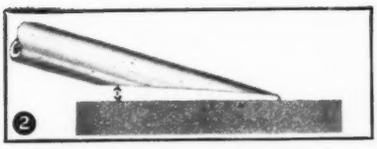
NEEDLE REPAIR TECHNIQUE



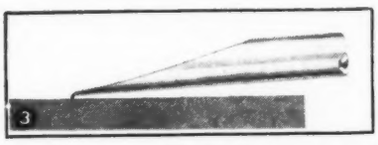
In all cases the original bevels on the needle point should be maintained



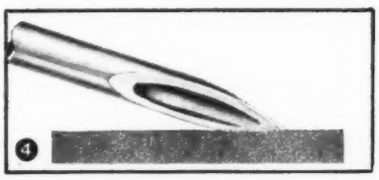
Fish hook points tear tissue and are painful



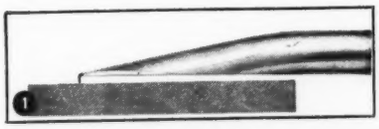
Removing inward fish hook on Regular Point



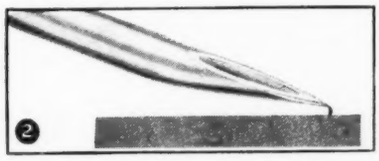
Removing outward fish hook on Regular Point



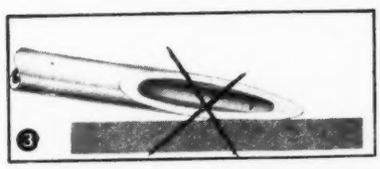
Note double angle used for grinding side bevels for both Regular and Huber Points



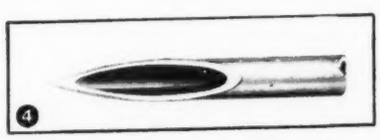
Removing inward fish hook on Huber Point



Removing outward fish hook on Huber Point



Wrong way to grind side bevels



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NEWS...

Lueth Is President-Elect of Nebraska Assembly

(*Continued From Page* 124.)

munity were persuaded that payments for indigent patients had to be raised.

A feature of the assembly was the excellent cooperation of Lincoln and Omaha newspapers in presenting the hospital story to the public. Under the chairmanship of T. J. McGinty, administrator of the Lincoln General Hospital, the program committee kept newspapers interested and informed throughout the assembly with the result that the papers featured hospital news. The committee also arranged for a broadcast during which Mr. Duncan, Mr. Whitehall and Mr. Jones discussed hospital problems with a radio station representative.

In addition to Dr. Lueth, officers elected during the assembly were: secretary-treasurer, Richard C. Wiebe, Mennonite Deaconess Hospital, Beatrice; trustee, Hal Perrin, Bishop Clarkson Memorial Hospital, Omaha.

Hawley and Allen Are Featured Speakers at A.N.A. Jubilee

NEW YORK. — Dr. Paul Hawley, chief executive officer of the National Blue Cross-Blue Shield commissions, and Dr. Arthur W. Allen, president of the American College of Surgeons, were featured speakers at the diamond jubilee of nursing banquet sponsored by the American Nurses' Association here November 16. The theme of the banquet, which was held to commemorate seventy-five years of nursing progress in the United States and to honor the memory of Linda Richards, America's first professional nurse, was "Appraising the Past—Charting the Future."

The American Nurses' Association, which represents 160,000 professional nurses, is presenting a three-point program to "help resolve the nursing crisis which affects the health of the American people"—according to plans announced at the meeting. These aims are: "to raise the economic status of the professional nurse to the level it deserves in order to attract and hold qualified nurses, to ensure adequate legal control through uniform state licensure laws, and to bring about more equitable distribution of nursing service."

In addition to Drs. Hawley and Allen, speakers included Dr. Ralph C. Williams, chief of the Bureau of Medical Services, U.S. Public Health Service; Dr. Frank P. Graham, president of the University of North Carolina; Ralph Blanchard, president of the National Conference of Social Work; Dr. Eli Ginzberg, Columbia University economist, and Pearl McIver, president of the American Nurses' Association.

N.Y.U.-Bellevue to Expand Regional Fellowship Plan

NEW YORK—The regional plan under which physicians on the staffs of nonteaching hospitals in suburban and rural communities have been receiving fellowship training at the New York University-Bellevue Medical Center here will be expanded following completion of its successful first year of operation.

The program will be expanded to include additional affiliated hospitals in Connecticut and Delaware as well as those already participating in New York, Long Island and New Jersey, it was explained. Fifty hospitals within a

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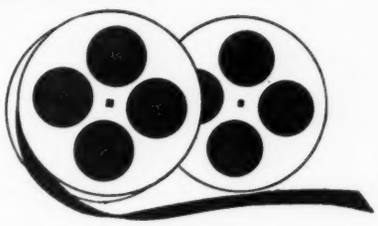
TECHNICAL INFORMATION: "Oxygen Therapy Handbook"; OXYGEN THERAPY BULLETIN; Case Charts; Cylinder Flow-Chart Tags; Cylinder Contents Tags; Caution Signs; and Nursing Procedures.



MOTION PICTURES: "Oxygen Therapy Procedures"; "Physiology of Anoxia"; "Oxygen Therapy in Heart Disease."

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NEWS...

radius of 150 miles of New York City have requested participation in the program, which is supported by grants from the W. K. Kellogg Foundation.

Under the plan, resident physicians of affiliated hospitals spend a year at the medical center studying the basic sciences and subjects applicable to their specialties. No tuition fees are paid by these students, whose maintenance is provided by their hospitals. Members of the university's medical faculty visit the hospitals on request.

"Times" Editorial Deplores Law Forbidding Practice of Medicine by Hospitals

NEW YORK.—Laws forbidding the practice of medicine by hospitals were criticized last month in a *New York Times* editorial entitled, "Hospital Service." The editorial commented on an address by Joseph G. Norby, president of the American Hospital Association.

"Only in their free clinics are hospitals allowed by law to practice medicine," the editorial said in part. "This is surely an anomaly. There is no technical reason why a sick person should not walk into any hospital of his choice and ask for staff service in a private or semi-private room for which he is willing to pay a reasonable price, but the law forbids. Though the sick are turning more and more to hospitals, largely because first-class medicine cannot always be praticed in a private office for lack of the proper diagnostic and therapeutic aids, the law remains.

"Hospitals need more certain sources of revenue than donations from the warm-hearted. Mr. Norby is probably right in thinking that industry is willing to contribute an even greater share to the support of hospitals than it does, and by industry he means not only employers but employes," the editorial continued. "The labor unions, too, have a large stake in good medicine and are likely to follow the example of the coal mines in insisting that more attention be paid to the medical needs of sick and injured workers. Blue Cross plans have been a financial boon to hospitals, but there is still opposition in some medical circles to their extension, so that they may include medical care in hospitals by staff physicians. Much of this opposition might disappear if hospitals conducted themselves as public institutions to which any qualified physician could bring his patients."

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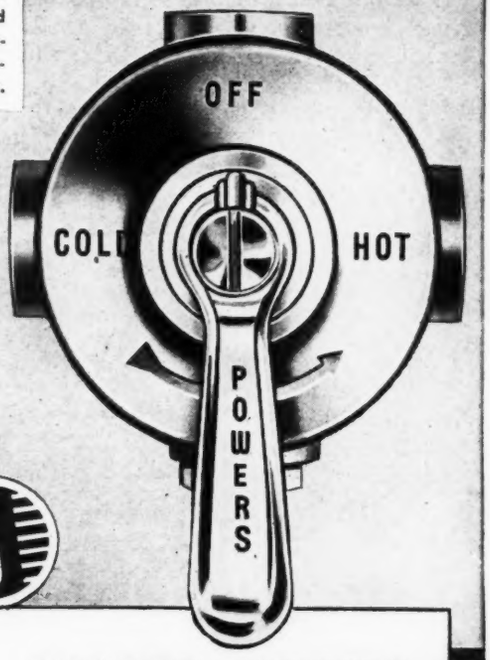

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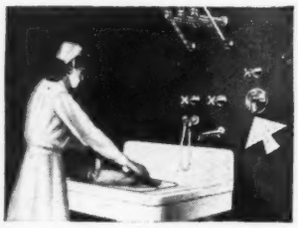


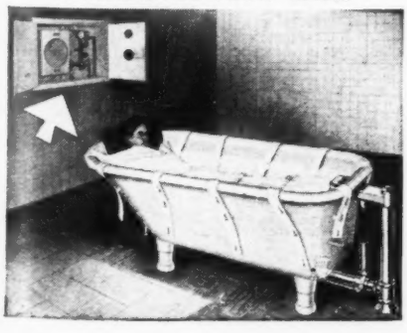
INFANT BATH

LEG BATH

ARM BATH

X-RAY DEVELOPER

CONTINUOUS FLOW BATH



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NEWS...

Crude Death Rate Is 10 Deaths per 1000

WASHINGTON, D.C. — The crude death rate in the United States for the first nine months of 1948 was estimated to be ten deaths per 1000 of estimated population, according to figures released here last month by the national Office of Vital Statistics, U.S. Public Health Service. The corresponding rate for the same period of 1947 was 10.2, the report said.

The majority of the states show increases in the rates between 1946 and 1947, five show no change, and twelve show decreases. The rates shown here are crude death rates, representing the total number of deaths per 1000 of estimated midyear population.

Crude death rates are affected by a number of factors in addition to mortality conditions, such as age-race-sex compositions in the population and completeness of death registrations, the office explained. Therefore, consideration must be given to these factors in comparing crude death rates either by state or by year. For example, a comparatively high crude rate does not necessarily indicate less favorable mortality conditions, it was explained.

Crude Death Rates
(Rates per 1000 estimated population)

Area	Rate 1947	1946
United States[1]	10.1	10.0
Alabama	9.3	8.8
Arizona	9.4	9.6
Arkansas	7.9	7.6
California	9.9	10.0
Colorado	11.0	10.6
Connecticut	9.7	10.0
Delaware	11.5	11.5
Florida	10.4	10.3
Georgia	9.2	8.8
Idaho	9.1	8.8
Illinois	11.2	11.2
Indiana	10.6	10.4
Iowa	10.2	10.1
Kansas	9.7	9.6
Kentucky	10.2	10.0
Louisiana	9.2	8.7
Maine	11.3	11.7
Maryland	10.5	10.3
Massachusetts	11.2	11.4
Michigan	9.4	9.4
Minnesota	9.6	9.5
Mississippi	9.6	9.4
Missouri	11.4	11.1
Montana	11.8	11.7
Nebraska	10.0	9.7
Nevada	11.7	11.3
New Hampshire	11.6	11.9
New Jersey	10.4	10.3
New Mexico	10.0	10.4
New York	11.1	11.1
North Carolina	8.2	7.8
North Dakota	9.7	9.5
Ohio	10.7	10.5
Oklahoma	8.5	8.1
Oregon	8.7	9.3
Pennsylvania	10.5	10.6
Rhode Island	11.2	10.9
South Carolina	8.8	8.6
South Dakota	9.9	10.0
Tennessee	9.2	9.2
Texas	8.8	8.6
Utah	7.8	7.5
Vermont	12.0	11.8
Virginia	9.7	9.4
Washington	9.3	9.6
West Virginia	9.1	8.9
Wisconsin	10.2	10.3
Wyoming	8.9	8.1

[1]Includes the District of Columbia.

Nursing Bill to Be Introduced

INDIANAPOLIS.—The Indiana State Nurses' Association will introduce a bill covering registration and examination of nurses as soon as the 1949 state assembly convenes, it was reported here.

Features of the bill are: a change in age requirement for state board examinations for professional nurses from twenty-one to twenty years and for practical nurses from nineteen to eighteen years; provisions to facilitate registration of out of state nurses, and provision for a list of "inactive registrants."

When oral feeding is not feasible following surgical procedures, severe hemorrhage, extensive burns or gastrointestinal disturbances, depend on the efficiency and safety of Abbott's protein hydrolysate, AMINOSOL 5% with Dextrose 5%.

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1. Christensen, H. N., Lynch, E. L., Decker, D. G., and Powers, J. H. (1947), The Conjugated, Non-Protein, Amino Acids of Plasma. IV. A Difference in the Utilization of the Peptides of Hydrolysates of Fibrin and Casein, J. Clin. Invest., 26:849, September.

NEWS...

Irradiation of Plasma Combats Jaundice Virus

AUSTIN, TEX.—Discovery of a means of combating the jaundice virus sometimes found in human blood plasma was reported here last month by Dr. Bettylee Hampil, director of virus research of Sharp & Dohme, Inc., Philadelphia drug manufacturer, at a meeting of the Texas branch of the Society of American Bacteriologists. Dr. Hampil said that for the first time under reproducible and controlled conditions it has been proved conclusively that irradiation, or treatment of blood plasma with ultraviolet rays, will prevent the danger of contracting jaundice in plasma transfusions.

After more than a year's intense experimentation, Dr. Hampil disclosed, she and her associates have designed and perfected a machine for large-scale irradiation of blood plasma. The machine is the first ever developed specifically for the commercial irradiation of plasma.

More than a year's work on improving the apparatus went into their efforts to irradiate so as to kill the virus and yet not affect the plasma, Dr. Hampil said.

Then they were ready for important clinical work headed by Dr. Joseph Stokes Jr. of the University of Pennsylvania School of Medicine. The clinicians injected fifteen human volunteers with serum known to contain the virus because it came from the blood of persons in the early stages of the disease. Of the fifteen, about half, or 47 per cent, contracted hepatitis. Another eleven volunteers were given almost double the dose of the same serum which had first been irradiated with ultraviolet rays. None of this second group showed the slightest sign of the disease during an observation period of five months.

These and other tests of irradiated serum and plasma show conclusively that they do not undergo chemical changes which could cause allergic reactions, Dr. Hampil stated. The scientists therefore conclude that the method is practical, safe and effective, and that their results strongly favor the routine use of ultraviolet treatment of serum and plasma under properly standardized conditions.

COMING MEETINGS

AMERICAN HOSPITAL ASSOCIATION, Mid-Year Conference of Presidents and Secretaries, Drake Hotel, Chicago, Feb. 4-5.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Book-Cadillac Hotel, Detroit, Aug. 23-25. Institute, Aug. 26, 27.

ARIZONA HOSPITAL ASSOCIATION, Phoenix, Feb. 11-12.

ASSOCIATION OF WESTERN HOSPITALS, Civic Auditorium, San Francisco, May 9-12.

CAROLINAS-VIRGINIAS HOSPITAL ASSOCIATION, Asheville, N.C., April 21-22.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N. J., May 18-20.

MID-WEST HOSPITAL ASSOCIATION, Kansas City, April 26-28.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, Mass., Mar. 28-30.

OHIO HOSPITAL ASSOCIATION, Neil House, Columbus, Ohio, March 23-26.

SOUTHEASTERN HOSPITAL CONFERENCE, Buena Vista Hotel, Biloxi, Miss., April 27-29.

TEXAS HOSPITAL ASSOCIATION, Buccaneer Hotel, Galveston, April 19-21.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 2-4.

UPPER MIDWEST HOSPITAL CONFERENCE, Minneapolis, May 26-28.

NEWS...

New Edition of Hospital Purchasing File Published

CHICAGO.—The twenty-sixth edition of *The Hospital Purchasing File* has been released and will be distributed to hospitals during the month of December, Everett W. Jones, publisher, announced here December 1. The Purchasing File is published by The Modern Hospital Publishing Company, Inc.

The 1948-49 edition contains 840 catalog pages from 300 manufacturers and distributors of hospital equipment and supplies, Mr. Jones said, in addition to more than 100 pages of editorial reference material. The reference section includes check lists of equipment and supplies for 50, 100 and 200 bed hospitals, articles on planning and equipping various hospital departments, and directories of hospital associations and agencies serving the hospital field.

"Hospital executives and their department heads will find this volume invaluable," Mr. Jones stated. It can also be used for in-service training of hospital employes and department heads, he said. This year's edition is being sent to all students in the eleven university courses in hospital administration, Mr. Jones announced.

Bureau of Standards Issues Supplement to CS146-47

WASHINGTON, D.C.—The National Bureau of Standards has issued a supplement to commercial standard CS146-47 covering gowns for hospital patients, it was announced here last month. The supplement becomes a part of the standard now in the hands of the hospital trade, it was explained.

The supplement reads: It is recognized that fabrics having a varying degree of shrinkage are used in the general production of gowns for hospital patients. Since it is not practical to set up measurements for gowns made from fabrics of every degree of shrinkage, the industry has adopted measurements applicable to fabrics having not more than 1 per cent residual shrinkage as determined by test methods for shrinkage in Textiles—Testing and Reporting, Commercial Standard CS59-44, as issued by the United States Department of Commerce.

"In view of the above fact, it is recommended that manufacturers using unshrunk fabrics or fabrics having a residual shrinkage of more than 1 per cent make proper shrinkage allowance."

NEWS...

Extending Group Practice Will Eliminate Fee Splitting, Clark Says

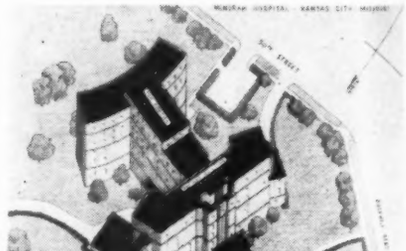
BOSTON.—Fee splitting and kickbacks in medical practice can be eliminated by the extension of group practice arrangements, Dr. Dean A. Clark, director of the Health Insurance Plan of Greater New York, said at a meeting here of the medical care section of the American Public Health Association. Fee splitting arises "almost inevitably" as a result of the private practice system and is bound to continue "in spite of all the laws and pronouncements that can be devised against it, so long as the individual system is the prevalent method of practice," Dr. Clark declared.

"The utter futility under our individual practice system of depending upon the medical profession to cope with this evil is illustrated by what occurred in New York in the fee splitting scandals under workmen's compensation a few years ago," Dr. Clark stated. He also cited recent disclosures of rebates in the optical industry as evidence that fee splitting in private practice is prevalent today. Failure of medical societies to suspend or expel physicians implicated in the workmen's compensation fee splitting exposé in New York was "a commentary not only upon the durability of fee splitting in the individual practice system, but also upon the ability of medical societies to set and maintain professional standards in general," Dr. Clark said.

Under the group practice system, on the other hand, payment is made to the group rather than to the individual physician and the patient knows and expects that the group will divide its income. Thus individual physicians lose no income when they refer a patient to another physician in the group, he explained. "Rather," he added, "the financial interest of each physician is best served if the most thorough and satisfactory job possible is done for the patient by the group as a whole."

Menorah Hospital Expands

KANSAS CITY, MO.—Construction of a $2,000,000 addition to Menorah Hospital here was undertaken last month, Dr. David Littauer, administrator of the hospital, reported. The new building will increase the bed capacity of the hospital from 135 to 300, Dr. Littauer said.



Site plan of Memorah Hospital addition

In addition to administrative offices, diagnostic services and additional space for patients' beds, the new building will house a psychiatric service, it was explained. Schmidt, Garden & Erikson of Chicago which designed the present hospital building eighteen years ago is the architect for the addition, Dr. Littauer stated.

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NEWS...

Medical Care Deteriorates Under Socialization, Dr. Cole Reports

CHICAGO.—Reporting results of a three-month visit to study the effects of Great Britain's health service on medical practice, Dr. Warren H. Cole of the University of Illinois School of Medicine said that "any advantage which might be cited to justify a government medical service is neutralized by the nose dive that medical care immediately takes."

Speaking at a meeting here last month of the Federation of Employes Benefit Associations, Dr. Cole said British doctors reported "tremendous increases" in the number of patients visiting their offices. "Overwhelmed by demands on their time, doctors do not have time to examine all patients thoroughly," Dr. Cole reported, "and the patient who makes the loudest complaint will be most likely to receive attention. The doctor has no incentive to do good work. There is no financial reward in sight and the stimulus of competition is gone.

"Thinking they are not paying for medical care, patients crowd the doctor's time with troubles they would otherwise disregard. Most doctors are unhappy and dissatisfied with socialized medicine and the result is a deterioration in their efforts."

Alcohol Hygiene Committee Announces Program for 1949

BALTIMORE. — Education looking toward the acceptance of alcoholics as general hospital patients will be an important part of the 1949 program of the National Committee on Alcohol Hygiene, Dr. Robert V. Seliger, executive director of the committee, announced here last month. Other objectives of the committee's scientific program for the coming year include establishment of training programs for physicians heading community organizations interested in the control of alcoholism and public education, particularly of high school and college students, on the medical facts about alcohol and the alcoholic.

The committee's hospital program will seek to present medical facts to the general hospital about handling and treating acute alcoholism and alcoholism in general and to gain the cooperation of hospitals in providing immediate aid for alcoholics, Dr. Seliger said.

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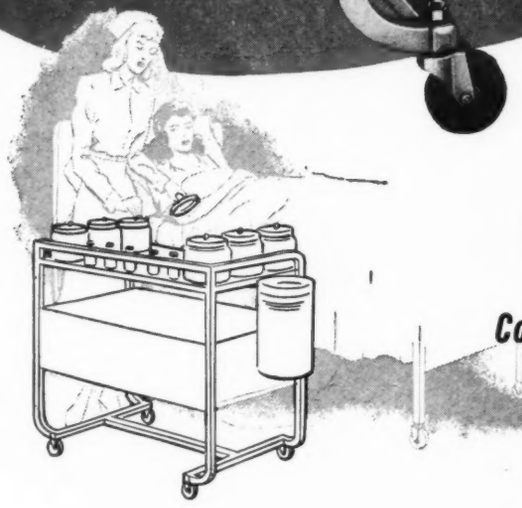

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NEWS...

New York City Hospitals Undertake Program of Home Care of Sick

NEW YORK.—A program of home care has been undertaken by the department of hospitals here in an effort to ease overcrowding of city institutions, Dr. Edward M. Bernecker, hospital commissioner, reported last month. Within a short time, Dr. Bernecker said, approximately 800 patients will be returned to their homes from five city hospitals, making that many beds available for the more seriously ill. Patients are now being cataloged and home conditions are being investigated so that cases may be selected for home treatment, the commissioner reported.

Under the projected program, home patients will be under the care of visiting physicians and public health nurses and will visit hospital outpatient departments wherever possible. "This is really an extension of the hospital ward into the home," Dr. Bernecker said. "Charts and records will be kept in the home as in the hospital. It is expected that three visits a week will be made to the patient by nurses from the city's home nursing organizations."

While the program is initially planned for patients in Queens, Morrisania, Bellevue, Kings County and Goldwater Memorial hospitals, Dr. Bernecker said that it would eventually be extended to include all the fourteen institutions in the department.

Ontario Hospital Meeting

Leaders of the Ontario Hospital Association talk over highlights of the twenty-fourth annual meeting held at the Royal York Hotel in Toronto, Ont., last month. Left to right: P. M. Morrison, J. MacIntosh Tutt, Priscilla Campbell and Dr. F. W. Routley.

Workshop on Brown Report

BLOOMINGTON, IND.—A workshop aimed at determining what state nursing groups should do in relation to recommendations made in the Brown report, "Nursing for the Future," will be held on the campus of Indiana University here January 5-7, it was announced November 1.

The five groups sponsoring the workshop will be the Division of Nursing Education of the University of Indiana, the State Board of Examination and Registration of Nurses, the State Nurses Association, the Indiana League of Nursing Education and the State Board of Health, the announcement said.

Taking part in the workshop will be, in addition to representatives of the nursing groups, interested physicians and hospital administrators, university and college presidents, executive officers of social agencies, faculty members of nursing schools and members of nursing school committees, directors of public health nursing agencies and potential patients or "consumers of nursing."

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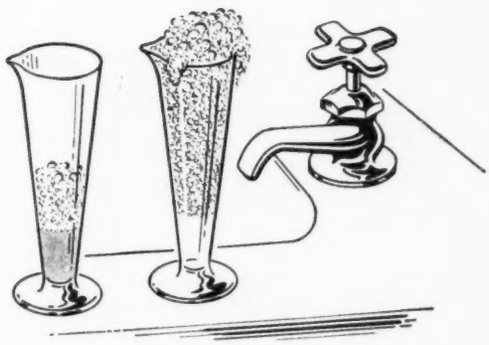

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Beaker at right holds the New Septisol Water Conditioned Surgical Soap mixed with ordinary tap water. Solution *clear*—foam action animated . . . long lasting. Proof of cleansing efficiency.

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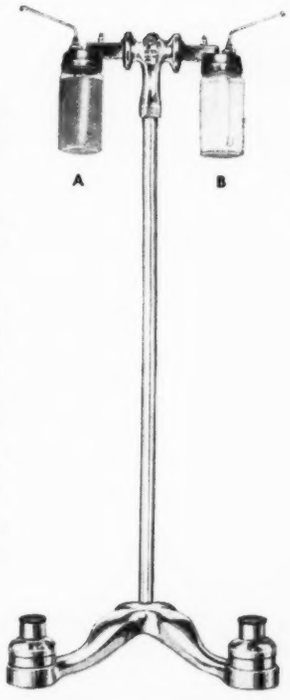

A Ordinary surgical soap diluted with tap water.

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NEWS...

Ewing Addresses State, Territorial Health Officers

WASHINGTON, D.C. — "Ruthless forces that close their eyes to the health needs of our people" are behind attacks on the President's proposal for a national health program including compulsory health insurance, Federal Security Administrator Oscar Ewing said in an address at the annual meeting of state and territorial health officers here last month. Mr. Ewing urged state and local public health officials to assume leadership in obtaining public support for the President's program.

Doctors who oppose the health insurance proposal are opposing the needs of "eight million people in this country for whom adequate medical care is completely beyond their resources," Mr. Ewing said. "Fortunately," he added, "there is an increasing number of younger more socially minded physicians who see the problem clearly in terms of national health."

The convention adopted a resolution recommending formation of a national department of health, education and welfare to be headed by a secretary with cabinet rank.

Committee Recommends Dividing Nursing Profession Into Two Distinct Groups

NEW YORK.—A specific program for division of the nursing profession into two distinct groups was recommended in the report of the Committee on the Function of Nursing released here last month. The committee recommended that the bulk of nursing service should be done by practical nurses. Two practical nurses are needed for every professional nurse, the study indicated.

Dr. Eli Ginzburg, associate professor of economics at Columbia University, is chairman of the committee which includes representatives from leading nursing, medical and educational organizations.

The committee estimated that 625,000 nurses would be needed in the United States by 1960. This would require that existing nursing schools enroll 85,000 new students every year, it was pointed out, if present methods are continued. The present shortage of nurses was estimated to be approximately 50,000.

The committee report said shortages were caused by "weaknesses in the financial structure of medical care and nursing education," lack of rewards combined with heavy workloads in nursing and "the important rôle which tradition and sentiment have played in nurse recruiting."

Under the program recommended by the committee, professional nurses would have a four-year educational course combining technical and academic training. Professional nurses for the most part would be concerned with planning and supervisory responsibilities and would work in teams with practical nurses trained for nonprofessional bedside duties.

The report suggested that nursing education may have to be supported by public funds. The present educational system was described as "antiquated."

Propose Medical Center for Louisville Area

LOUISVILLE, KY.—Plans for a large scale medical center which will serve the needs of an extensive area in Southern Indiana and Kentucky were announced here last month. The program includes state-owned hospitals and training schools to be situated in a Kentucky Memorial Medical Center at Louisville, a community hospital at New Albany, Ind., a clinic at Corydon, Ind., and eventually an addition of sixty-five beds to the present hospital serving the community of Jeffersonville, Ind.

The proposed center would be built around the area now occupied by the Louisville General Hospital. Federal and state support is contemplated, and the program also proposes transfer of the city-owned University of Louisville School of Medicine to the University of Kentucky. The plan also provides for a university school of nursing.

Altogether, the Louisville Area Development Association and Louisville Hospital Council, which conducted the studies leading up to the proposals as a joint project, estimated that there should be 1988 beds in the proposed medical center by 1950 and 3269 beds by 1970.

Donate Hospital Ambulance

MORRISTOWN, N.J.—The gift of a new ambulance to Morristown Memorial Hospital here was announced last month. The ambulance was donated to the hospital by Mr. and Mrs. P. H. B. Frelinghuysen.

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even in the presence of pus, blood,
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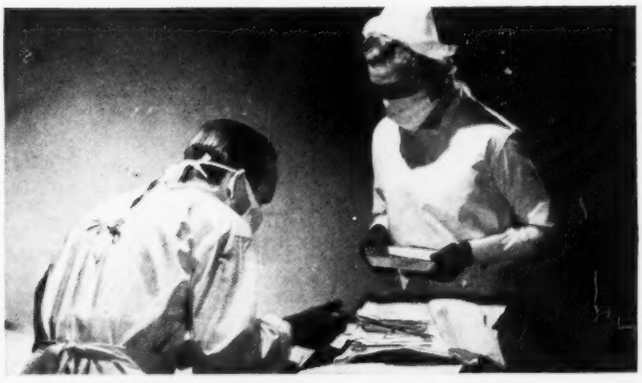

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NEWS...

Joint Fund Raising Not a Success, O'Connor Tells Foundation Group

CHICAGO.—A joint fund raising campaign combining the interests of a number of voluntary health agencies would not succeed in raising as much money as individual agencies produce by going to the public with their own needs and programs, Basil O'Connor, president of the National Foundation for Infantile Paralysis and of the American Red Cross, said here last month.

"To combine appeals and hold one joint drive instead of several separate ones would mean that there would be less money to carry on the nationwide fight against infantile paralysis," Mr. O'Connor said at a conference of foundation executives and advisers. "It is a well established and easily demonstrable fact that people give less when asked to contribute at one time all they are going to give in one year than when they are asked to contribute several times during the year," Mr. O'Connor asserted.

The success of the national foundation could be attributed, he said, to its operation as an independent voluntary organization with funds that are freely available when needed.

U.H.F. Studies Relation Between Cost and Income of New York Hospitals

NEW YORK.—The relationship between income and cost in fifty-two member hospitals was the subject of a special study reported last month by the United Hospital Fund of New York. The study covered operations during the calendar year 1947, it was explained.

On private room service in the member hospitals, the average per diem income exceeded average cost by $4.57, the report said. The excess of income over cost on private room service was $1.70 for special services and $2.87 for room, board and routine service, it was explained.

On semiprivate services, average per diem income exceeded cost by $1.90—85 cents on special services and $1.05 on room and board.

Ward service, the report indicated, cost the average hospital $3.98 per patient day—the excess of expense over income on the average ward service patient. The breakdown of this figure was reported at 71 cents net loss on special services and $3.27 on room and board.

Physicians Open Interracial Hospital in New York

NEW YORK.—Mount Morris Park Hospital was opened here last month by a group of ninety physicians who will operate the institution cooperatively on an interracial basis. According to the group, the fifty-bed hospital will "fill a great need in the Negro medical profession."

It is not intended that the Mount Morris Park Hospital should compete with Sydenham Hospital, now operating an interracial institution, it was explained. Rather, the new hospital will meet the need of doctors without hospital affiliation who have been experiencing difficulties obtaining hospitalization for their patients.

William A. Traynham, administrative assistant at Harlem Hospital, is executive director of the new institution.

ABOUT PEOPLE

(*Continued From Page 78.*)

years ago as administrative intern, receiving the first appointment of its kind granted a Negro in voluntary hospitals anywhere in the United States. Subsequently, upon the resignation of **S. L. Friedman, M.D.,** as executive director of the hospital, Mr. Adair was named acting executive director, pending the appointment of a medical administrator. He is an alumnus of Morehouse College and did his postgraduate work at Harvard University Graduate School of Business Administration.

Frank R. Shank

Frank R. Shank, assistant superintendent of clinics at the University of Chicago, has been appointed to direct the administration of Chicago Lying-In Hospital and Dispensary of the University of Chicago. At the same time, **Mrs. Mildred H. Mitchell** and **James Connelly** were named administrative assistants in the clinics. Mrs. Mitchell was appointed administrative assistant at Lying-In, and Mr. Connelly, of the clinics outpatient department. A 1947 graduate of the University of Chicago's hospital administration program, Mr. Shank has served as coordinator of the program since 1947.

J. F. Friedheim

Joseph F. Friedheim, formerly an administrative assistant at Johns Hopkins Hospital, Baltimore, has been appointed director of Jameson Memorial Hospital, New Castle, Pa., to succeed **C. R. Youngquist.** Mr. Friedheim received his master of arts degree from the University of Chicago in 1946.

David Disch was appointed assistant superintendent of Maumee Valley Hospital, Toledo, Ohio, in September.

The Rev. Clarence A. Morrill is the new assistant director of Methodist Hospital, Brooklyn, N.Y. He was formerly associated with the New England Deaconess Hospital, Boston.

John Hughes is now administrative assistant at Worcester City Hospital, Worcester, Mass. Mr. Hughes received his B.S. degree in hospital administration from Northwestern University in August and interned at Evanston Hospital.

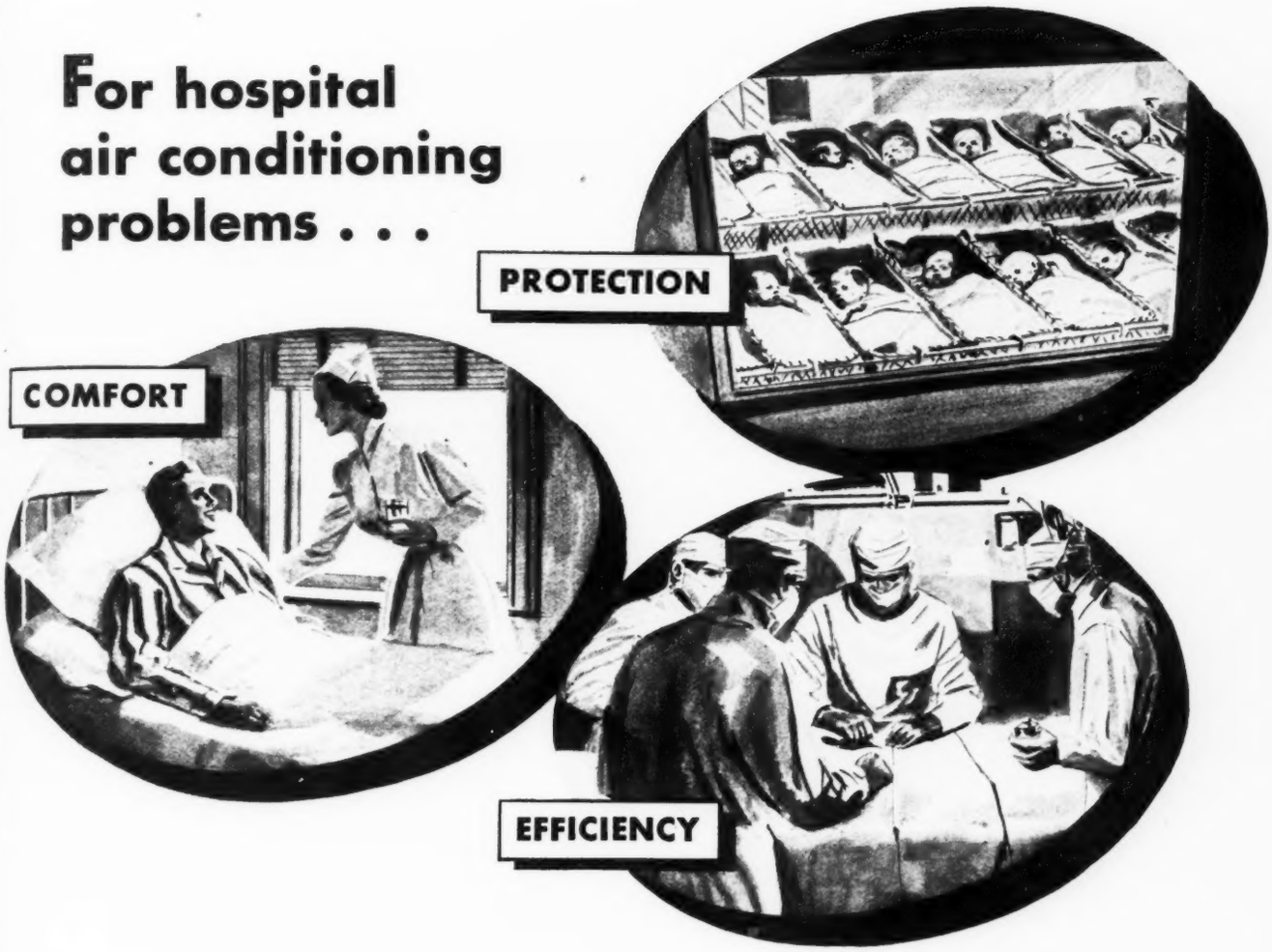
Burton M. Battle

Burton M. Battle assumed his duties on October 18 as administrator of George H. Lanier Memorial Hospital, Langdale, Ala. Mr. Battle was formerly director of New Orleans Hospital and Dispensary for Women and Children, New Orleans. He is a past president of the Southeastern Hospital Conference.

Paul Kempe, formerly assistant administrator at Lutheran Deaconess Hospital, Chicago, is now superintendent of Saranac Lake General Hospital, Saranac Lake, N.Y.

Dr. Sidney M. Samis has been appointed assistant director of Mount Sinai Hospital, New York City. Dr. Samis is a graduate of Lafayette College and the St. Louis University Medical School and holds the degree of master of public health from the University of Michigan.

For hospital air conditioning problems . . .



. . . specify dependable G-E equipment

Many modern hospitals are providing extra protection and comfort for both patients and staff through G-E Air Conditioning systems.

G-E air conditioning in operating rooms can help to relieve nervous strain on the operating staff. In recovery rooms it can stimulate recuperation of convalescing patients. In offices, wards and other areas it can be an important factor in attracting to the hospital physicians, surgeons and nurses of the highest professional competence.

General Electric equipment has been designed and built for the dependable performance so essential to hospital use. And G-E economy of operation keeps air conditioning costs well within the average hospital budget. It will pay you to call your local G-E Air Conditioning specialist for full information. *General Electric Company, Air Conditioning Department, Section A86712, Bloomfield, New Jersey.*

G-E Central Plant Air Conditioner. For operating rooms, labor rooms and nurseries.

G-E Packaged Air Conditioner. For wards and waiting rooms.

G-E Remote Room Air Conditioner. For offices and patients' rooms.

GENERAL ELECTRIC

Better Air Conditioning

Department Heads

Sister Mary Louis Wenzl is the newly appointed director of Creighton Memorial, St. Joseph's Hospital School of Nursing, Omaha, Neb. She succeeds **Sister M. Livina Thompson,** who died October 1 after serving as director for thirty years.

Warren E. Toy, former purchasing agent of Wesley Hospital, Wichita, Kan., is now at General Rose Memorial Hospital, Denver. **Mrs. Juanita McPherson** is the new purchasing agent at Wesley.

John L. Hurley has been named business manager of St. Francis Hospital, Grand Island, Neb. Mr. Hurley, who has had public relations experience, spent several years in the army medical administrative corps during World War II.

Sister M. Hugolina Peoples, assistant director of St. Joseph's School of Nursing, Omaha, Neb., for the last two years, has been assigned as director of St. Anthony Hospital School of Nursing, Denver.

Mrs. Maxine Jacks has been named director of nursing education of Clarkson Memorial Hospital, Omaha, Neb. She succeeded **Mary E. Carder,** who resigned December 1.

Eleanor Page Bowen, associate professor of nursing education at the Boston University School of Nursing, has been appointed to serve a six-year term as a member of the board of registration in nursing for Massachusetts.

Constance White has resigned as director of nurses and director of the school of nursing at Touro Infirmary, New Orleans, to accept the position of assistant chief, Nursing Standards and Operations Division, in the central nursing office of V.A. in Washington.

Miscellaneous

Rev. George Lewis Smith, president of the Catholic Hospital Association, has been elevated to the rank of Right Reverend Monsignor. Father Smith has been director of hospitals for the diocese of Charleston, S.C., since 1938.

Harvey R. Schoenfeld, director of personnel and management engineering of St. Vincent's Hospital, has been elected the first president of the Association of New York City Hospital Personnel Executives.

Alfred L. Golden has been appointed a vice president of United Medical Service, New York City. Mr. Golden is public relations director of United Medical Service and also of Associated Hospital Service, New York's Blue Cross plan.

Cost of Care for Respirator Cases of Polio Is Around $1300 per Month

CHICAGO. — "The cost for hospital services for a respirator case of polio is about $1300 a month," James D. Cunningham, chairman of the Cook County chapter of the National Foundation for Infantile Paralysis, told members of the Chicago Junior Association of Commerce at a meeting last month in discussing the 1949 March of Dimes, which opens in January. "Many people find it difficult to meet even a part of the costs; some cannot afford them at all," Mr. Cunningham said.

When the disease strikes the young family, it usually imposes an economic problem for which it is wholly unprepared, it was explained. "The National Foundation has been set up to serve just such people. It helps all who need financial assistance in providing medical care for polio victims."

Mr. Cunningham pointed out that relatively few people can afford polio costs. "In such instances March of Dimes funds are available," he said.

This TILE-TEX FLOOR has been SAVING DOLLARS since the day it was laid

Tile-Tex Dining Room, City Hospital, Akron, Ohio

Tile-Tex, easy to clean, easy to keep clean and remarkably easy to repair*

Hospital costs—*they're going up fast!* But they don't *need* to go up so far nor so fast in *every* department.

Consider the cost of keeping floors *clean* and in *good repair* in hospitals where floors are Tile-Tex Asphalt Tile. Good-looking, long-wearing, smooth-surfaced Tile-Tex floors are *easy* to clean, easy to *keep* clean.

And for repairs—due to accidents or alterations—Tile-Tex units are easily and quickly replaced, and the cost is trifling.

Tile-Tex floors have *proved* their money-saving as well as long-time attractive appearance in hospital corridors, wards, clinics, reception lobbies and other areas subject to heavy foot traffic.

And remember Tuff-Tex* *Greaseproof* Tile for kitchens, pantries, and cafeterias where spillage of foods and greases is apt to be frequent.

Cost-conscious hospital business managers, architects and consultants choose time-tested Tile-Tex flooring, which offers, in addition to maintenance savings, so many attractive colors and designs.

Write, today, for the name of the Tile-Tex Flooring Contractor nearest you. He will, if you wish, make a study of your floor areas and suggest the Tile-Tex products best qualified to meet the service requirements of each area. No obligation, of course. THE TILE-TEX COMPANY, INC. (subsidiary of The Flintkote Company), Chicago Heights, Illinois. Sales offices located in Chicago, New York, Los Angeles, New Orleans, Montreal and Toronto.

Asphalt TILE-TEX CO. INCORPORATED Tile

Tile-Tex Asphalt Tile

*REGISTERED TRADEMARK OF THE TILE-TEX COMPANY, INC.

THE BOOKSHELF

THE HOSPITAL BUILDING. *Comprising the Proceedings of the 1947 A.I.A. Convention Hospital Seminar.*

The foreword by Marshall Shaffer to this splendid addition to hospital literature outlines the scope of the proceedings. From the foreword through to the end of the bibliography, hospital planners will find much of value.

Dr. R. M. Atwater of the American Public Health Association and the National Health Council points out the importance of combining local health services and the community hospitals. Jacque Norman, chairman of the A.H.A. Council on Plant Planning and Operation, gives a splendid overall picture of hospital design and its effect on administration. Mr. Norman points out that patients, because of their almost complete ignorance of professional problems, rarely have any understanding as to the quality of professional care received. He states that, on the other hand, almost everyone entering the hospital is fully capable of judging and is usually extremely vocal on the subject of the food received.

Mr. Norman points out the wide discrepancy in the costs of heating per bed per year. He shows that this figure goes from a low of $50 to a high of $125. I believe that Mr. Norman would have added a great deal to his discussion had he emphasized at this point the importance of such equipment as automatic draft controls, stokers, gas and oil burners, carbon dioxide and stack temperature controls. Too few hospital architects, consultants, administrators and others give enough emphasis to the great fuel economies inherent in the use of proper equipment in the boiler room.

William A. Riley, architect of Boston, presents a splendid discussion on outlining the hospital program. Schematic plans for hospitals as outlined by architect Perry B. Johanson give a vivid presentation of traffic flows in and out of the hospital. The following statement in this connection is significant: "The necessity for a direct and obvious approach cannot be overemphasized."

Isadore Rosenfield of New York City does a splendid job in discussing the "Comprehensive Approach to Hospital Planning." The following statement by Mr. Rosenfield is especially significant and should be considered carefully.

"The trend in hospital planning is definitely to place health (preventive activity) and hospitals (remedial activity) under one roof. This phase of integration permeates planning on all levels from the rural health center to the great medical teaching and research center. The main purpose of this is, of course, the conservation and the promotion of professional skills and resources for the benefit of the community. From the building point of view the placing of health and hospital activity under one roof should result in economy of construction, operation and maintenance."

Addison Erdman discusses the space requirements of many elements of the hospital. I was interested by his reference to the tearoom or lunch counter. This is a convenience for both employes and visitors which hospitals can no longer afford to do without. In discussing the sizes of the nursing units, Mr.

Erdman uses figures of twenty to thirty beds as a standard. I question whether these figures should be considered a rule. Many students of hospital planning and operation today feel that nursing units housing up to forty or even fifty patients are entirely practical and more economical to operate than are the smaller units.

Statements by Miss Ward of the American Nurses Association and Miss Mayo of the National League of Nursing Education as to what nurses want in hospitals are of particular significance. Their statements tie in with the discussion carried on in The MODERN HOSPITAL round table on hospital planning as published in the March 1948 issue. Too much emphasis cannot be placed on the importance of calling nurses and other hospital employes into conference when the departments which they must operate are being planned.

Carl Erikson makes a significant contribution in his discussion. He emphasizes the necessity of more intensive study so that hospitals can be planned to reduce labor and mechanical upkeep costs. The following statement by Mr. Erikson is of particular importance: "It shall come to pass, I believe, that there will be just as much attention given to 'production' in the hospital as there is in the factory." Mr. Erikson urges that as hospitals, and therefore their boiler plants, become bigger that accurate control equipment and instruments must be installed to ensure economy in fuel consumption.

The splendid bibliography at the end of this report is alone worth the modest price of the book. Members of the American Institute of Architects can buy the report for $1, nonmembers, for $2. I urge everyone concerned with the planning, building and operating of hospitals to read this fine report from the Department of Education and Research of the A.I.A.—EVERETT W. JONES.

ESSENTIALS OF NURSING. *By Helen Young, R.N., and Eleanor Lee, A.B., R.N., and Associates. Second edition.* 530 *pages. Illustrated. New York: G. P. Putnam's Sons.* 1948.

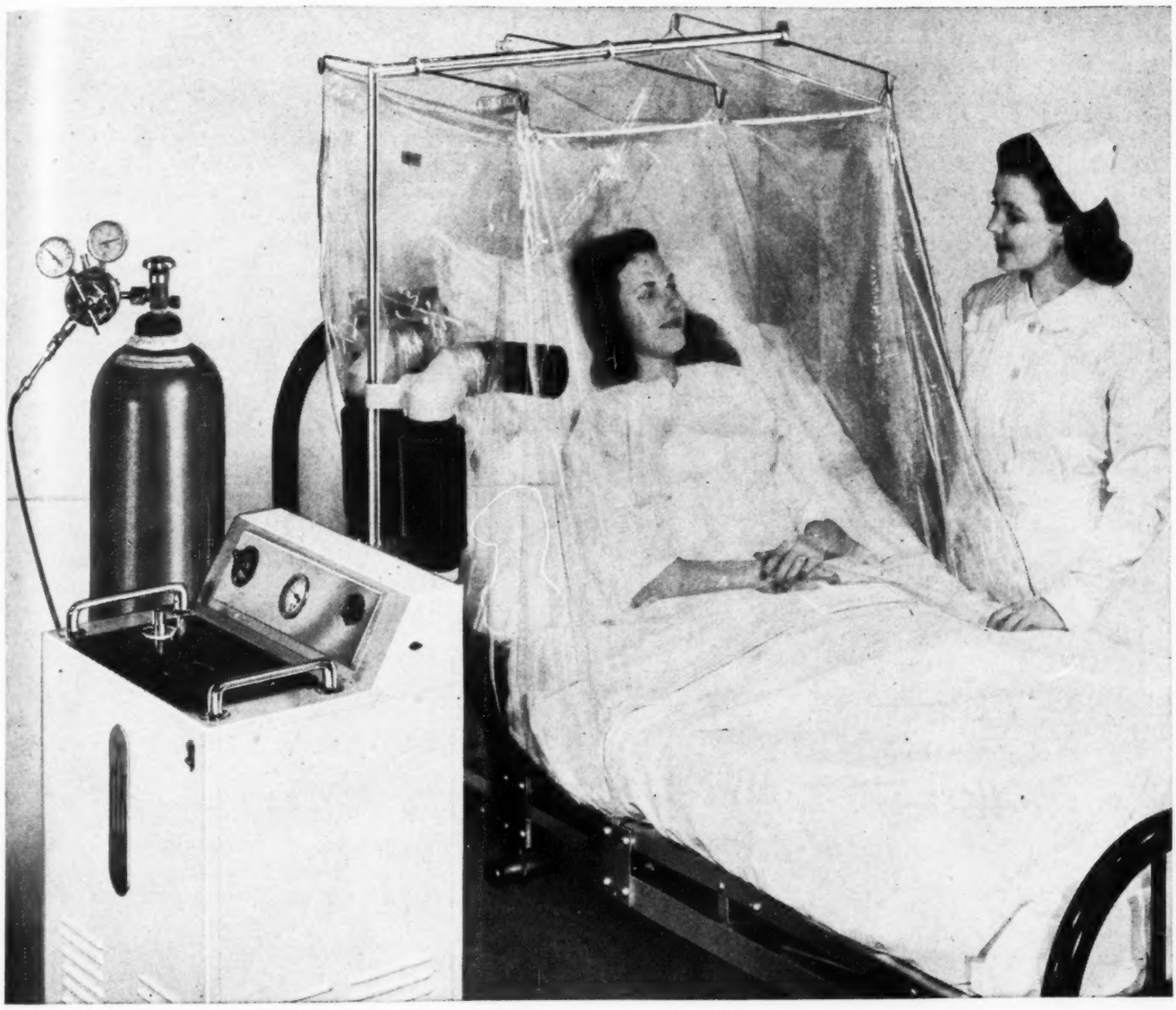
Teachers and students in nursing education will welcome this new up-to-date edition of "Essentials of Nursing." The second edition is a text and reference book that will be helpful and is compiled to hold the reader's interest and attention. Two new sections have been added: "Social Aspects of Patient Care, and Modifications of Basic Nursing Care to Meet the Needs of the Acutely Ill and the Dependent Patient." The other chapters have been revised and new material has been written, *i.e.* the administration of penicillin and streptomycin, and the Rh factor in transfusions. The changes not only provide technical skills and broad scientific knowledge, but place emphasis upon the patient as an individual. The principles are clearly set forth and although lists of equipment have been omitted, general procedure methods are added which are helpful in clarifying and visualizing the approach to the specific procedure.

The line drawings by Mrs. Helen B. Pristop showing nursing technics and equipment are valuable to students and instructors in teaching and demonstrating. Suggested readings following each chapter stimulate and maintain the student's interest. The excellent charts, graphs and outlines give detailed data which are easily accessible and provide invaluable material for study.

The book consists of a foreword to the first and second editions, four parts, appendices, and index. Part I discusses the "Relationship of the Nurse to the Patient and Hospital." Emphasis is placed not only on ability and skill, but on the nurse's genuine good will and understanding of the patient's mental outlook which affects his physical improvement.

In the section on "The Social Aspects of Patient Care," a "consideration of practical problems confronting the patient" is discussed. The nurse must have an awareness of the social needs of the patient and his family so that she may refer such problems to the appropriate person or agency. The chapter discusses the large number of various agencies affiliated with or pertaining to public health nursing which familiarizes the student with these outside sources.

Part 2 deals with "Basic Nursing Care." Here the emphasis is placed upon the comfort and welfare of the patient with an adjustment of the pattern for care to each individual patient. Suggestions for improvising equipment in the home are interspersed throughout. The nurse must continue to combine the mental, physical and social aspects of her patient's care with her increasing educational knowledge. The definitions and sections on medical and surgical asepsis are clearly outlined and examples are presented for clarification.



HISTORY REPEATS with CONTINENTALAIR

Once you've equipped your hospital with its first Continentalair iceless, automatically controlled oxygen tent, you'll discover first hand the many time-proven advantages of this equipment... and knowing Continentalair's efficient, economical and simplified operation, you will add additional units to your oxygen service.

Since the first Continental iceless, oxygen tent was built twelve years ago, hundreds of hospitals have modernized their oxygen administration facilities by buying additional Continentalairs with the income provided from the initial installation.

Today more than 4000 Continentalairs are providing maximum efficient service in leading hospitals throughout the world.

For those who want to know all about modern, oxygen administration equipment and detailed features of the Continentalair, we have prepared a booklet, which will be mailed without obligation.

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Part 3 is a comprehensive presentation of "The Rôle of the Nurse in Diagnostic and Therapeutic Procedures." It deals with advanced nursing procedures presenting valuable information and technics. Here, again, definitions, mental and physical preparation of the patient, aftercare of the patient, and the responsibilities of the nurse are clearly, factually and concisely presented. The student's thinking is stimulated by a discussion of the current and newer trends of scientific thought, and controversial problems are presented rather than absolute statements of fact. The sections contain clear descriptions of procedures, examinations and tests; their purposes and pertinent factors in successfully carrying out the procedures.

Part 4 is the new material on "Adaptations of the Basic Principles of Nursing Care." This section demonstrates the importance of the adaptations that can be made for the acutely ill or dependent patient, the convalescent and operative patient with a thorough knowledge and understanding of basic nursing care.

In the second edition Young and Lee again demonstrate their leadership in the nursing field; they have advanced and broadened the student's knowledge of nursing skills, principles and practices.

This book is written in an easy, flowing style in which the basic principles and technical facts are interwoven in such a manner that the material presented is both interesting and stimulative. "Essentials of Nursing" is a contribution toward the furthering of the nursing profession.—GERTRUDE KROGER, R.N.

SURGICAL NURSING. *By Robert K. Felter, M.D., Frances West, R.N., and Lydia M. Zetzsche, B.S., R.N. Philadelphia: F. A. Davis Company.* 1948. Pp. xvii-692.

This book was originally published eleven years ago and has undergone a number of changes through its four previous editions as is natural with any text presenting technics in a field in which new developments occur right along.

As in previous editions, the present text includes separate sections covering operating room nursing, general postoperative care, and special problems developing in connection with the care of patients in all the various major surgical classifications.

The new edition includes a section on nursing care of the eye, ear, nose and throat which did not appear in previous editions. The sections on orthopedic care and burns have been rewritten, according to an introductory note by the authors, and chapters have been added on refrigeration anesthesia and nursing problems in the care of the vagotomy patient.—ROBERT M. CUNNINGHAM JR.

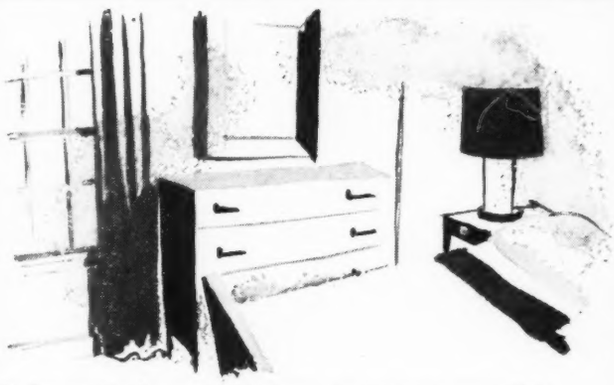
CONTROL OF PAIN WITH SADDLE BLOCK AND HIGHER SPINAL ANESTHESIA.

This Ciba publication is an excellent summary of an extensive literature on this subject. It provides the casual reader with a vast amount of accurate information and supplies a useful bibliography. Such a treatise makes possible a more widespread understanding of the applicability of technics which are steadily increasing in popularity without burdening the individual with too much minute detail. The illustrations tend to clarify the written material and are sufficiently accurate to fulfill the purpose for which they are intended.—J. EARL REMLINGER, M.D.

Here's how to solve all your hospital's cleaning problems!

From the lobby—Hospitals must be spotless from the lobby to the "labs." Keep your lobby and waiting rooms clean and inviting by using LIQUID SCRUB SOAP on your linoleum, terrazzo and marble surfaces. And for your washrooms—use LIGHTHOUSE CLEANSER and LIGHTHOUSE WASHING POWDER.

Along the corridors—Along the long, busy hospital corridors, there are many cleaning problems. To keep the corridors shining, use HOSPITAL GREEN SOAP. Put FORMULA NO. 99 ANTISEPTIC SOAP in the operating room for surgical scrub up. (Remember Armour's GLYCERINE in the hospital pharmacy.)



To the patient's room—To keep the patient's room light and bright there's: REGAL DETERGENT for the mirrors and windows—NO. 422 SYNTHETIC DETERGENT for the walls—ROYAL FLAKES for the blankets and bedspreads. And put a bar of CLIPPER in every room for the patient's own use.

And from the kitchen—To help maintain the high sanitary standards of your kitchen, there's LIGHTHOUSE WASHING POWDER. To lighten the work of your kitchen staff there's NO. 422 SYNTHETIC DETERGENT—and for spotless ranges, pots and pans, there's LIGHTHOUSE CLEANSER and TOPAZ CHIPS.

To the laundry—Your laundry, too, has high standards of cleanliness to maintain. To keep your linens really white, use FLINT CHIPS. And there's HILO POWDER for your colored work. For your heavy laundry work, try GIANT POWDER, the ready-built soap made to stand up under high temperatures.

There's an Armour soap for every cleaning problem in your hospital

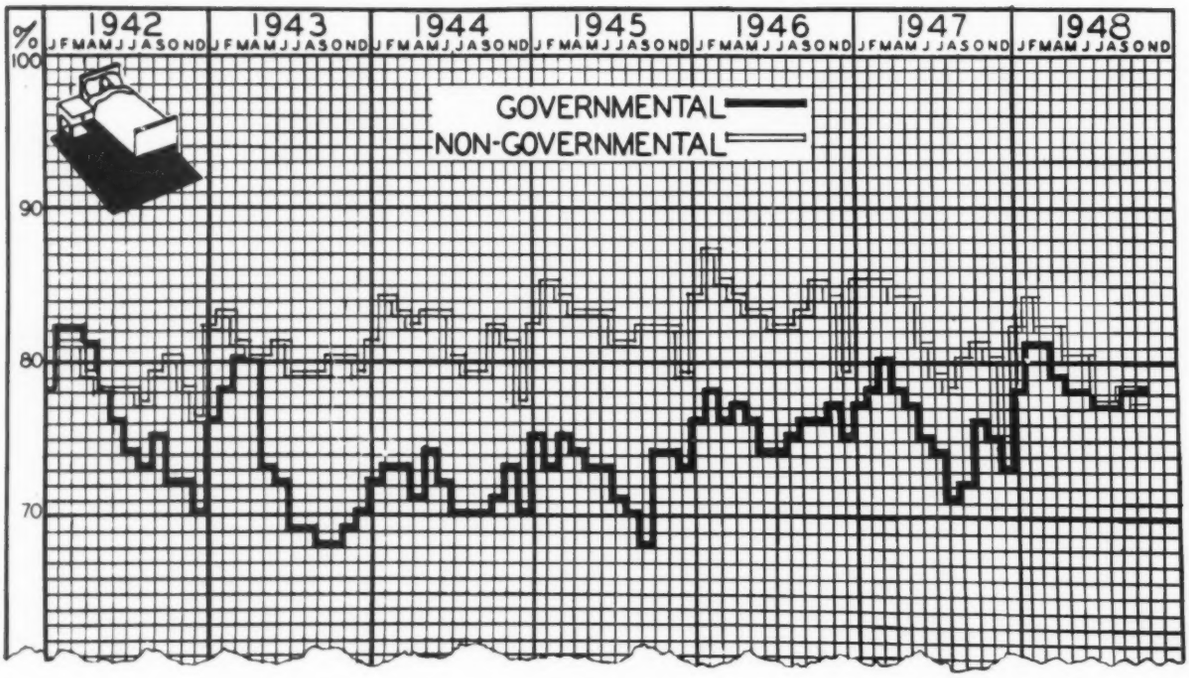
ARMOUR

Industrial Soap Division

ARMOUR AND COMPANY

1355 W. 31st • CHICAGO 9, ILLINOIS

Hospital Construction Totals $696,550,769



Slackening of demand for hospital beds is again evident in the Occupancy Chart figures for October. Nongovernmental hospitals reported 77.4 per cent occupancy—slightly less than in September (a reversal of the usual seasonal progression)—and definitely less than the occupancy at this time last year. Governmental hospitals, at 78.1 per cent, were up a little from the previous month and from October 1947.

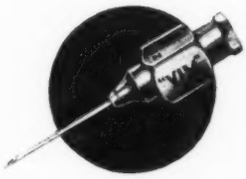
Construction projects reported during the month of November brought the total for the year to $696,550,769, compared to only $402,376,728 at this time a year ago. Ninety-five construction projects were reported for the month.

What's New FOR HOSPITALS

DECEMBER 1948 Edited by BESSIE COVERT

FOR further information on new products see coupon on page 236

Laminex Needle



The new Vim hypodermic needle is made of "Laminex" stainless steel, a new laminated steel with the temper of high carbon steel which is only now being made available for hypodermic needles.

Needles made of the new steel are stiff enough to prevent easy bending and destruction of the point, yet hard enough to prevent premature deflection. Unique in strength, toughness and freedom from breakage, the new needles take and hold a sharp point and cutting edge indefinitely. In addition, the new needles have all of the fine qualities of earlier Vim needles. **MacGregor Instrument Co., Dept. MH, Needham 92, Mass. (Key No. 279)**

Plastic Covering Material

Kalistron is a plastic covering material which is scuffproof, scratchproof, spotproof, waterproof, flame resistant and which cannot chip, crack, peel or shrink. The color is fused to the underside of a strong, transparent sheet of special Vinylite Plastic, giving a rich, deep tone to the several colors in which the material is available. It can be printed with any design or pattern and colors can be matched.

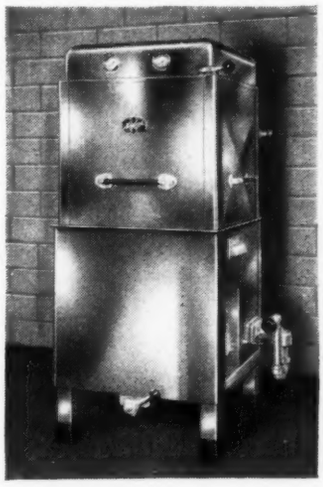
Kalistron can be used for upholstering furniture, as a wall covering and for counter tops. It is attractive in appearance, will wear indefinitely and is easily cleaned. It is made by Deco-Plastics, Inc., and distributed by **United States Plywood Corp., Dept. MH, 55 W. 44th St., New York 18. (Key No. 280)**

Developer Hanger

The processing of Kodak Photoflure Film and Kodak Cardiograph Papers can be facilitated with the new stainless steel adjustable developing hanger recently introduced. It will take all widths from 35 mm. to 70 mm. and lengths up to 11 feet. The new unit holds films and papers smooth and taut during the processing and should prove particularly useful for hospitals employing deep tanks and handling a large volume of work daily. **Eastman Kodak Co., Dept. MH, Rochester 4, N. Y. (Key No. 281)**

AM-7 Dishwashing Machine

The new AM-7 glass and dishwashing machine is a heavy-duty, semi-automatic rack-type model designed to do the major job in medium-sized kitchens. The completely new water distribution



system features a high speed wash. The wing-type rinse sprayers and double-end nozzles above and the pick-off revolving lower rinse arms with curved ends provide water action which quickly strips the food from the dishes. The single-handle control with interlocking device makes it impossible to open the doors while wash or rinse is on.

The unit is made of stainless steel with newly designed doors with long insulated handles. The regular wash water overflow with large skimming surface and lift-off cap is augmented by an auxiliary overflow for plumbing code compliance. Other features include pick-off type, easily removable cabinet cover; dial type wash and rinse thermometers; easily operated drain lever; thermostatically regulated steam injector or gas burner, and conveniently located fill valve. The machine occupies a minimum of space considering its capacity and is designed for straight wall or corner installations. **The Hobart Mfg. Co., Dept. MH, Troy, Ohio. (Key No. 282)**

Aerosol Penicillin Pump

Antibiotics adapted for aerosol therapy can be administered by means of the Gomco aerosol penicillin pump. This compact unit provides compressed air which can be regulated to provide the proper strength without going beyond safe pressure. Replaceable filters on both intake and outlet lines ensure clean air. The unit weighs 15 pounds and tubing and attachments can be easily removed for cleaning and can be sterilized by boiling or by immersion in sterilizing solutions. **Gomco Surgical Mfg. Corp., Dept. MH, Buffalo 11, N. Y. (Key No. 283)**

Overbed Table

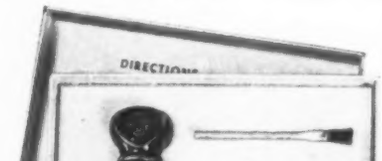
The new overbed table developed by American Hospital Supply Corporation is of single pedestal design for use with either bed or chair. It has 2 inch ball bearing swivel casters for easy mobility and can be adjusted in height from 29 to 44 inches. The three prong base gives great strength, stability and durability and the table has a convenient adjusting lever which is within easy reach of the patient.

The mirror, removable tray and book rest in the table top are available from both sides, thus making it easy to position the table. The fine grained, polished, laminated hardwood top resists scratching or marring and is 34 inches long and 14 inches wide. It is available in three finishes: silvermist, walnut or

maple. **American Hospital Supply Corp., Dept. MH, Evanston, Ill. (Key No. 284)**

Applegate Mark-It

A new small stamp and ink set for marking individual linen has been introduced by Applegate. Nurses and



other personnel will find the Applegate Mark-It set particularly helpful for marking uniforms and other personal property easily, quickly and indelibly with a mark that will last the life of the garment.

Consisting of a marker with name in ⅛ inch letters, a bottle of Applegate indelible ink, three extra felt ink pads and brush, the handy set is enclosed in a box. **Applegate Chemical Co., Dept. MH, 5632 Harper Ave., Chicago 37. (Key No. 285)**

Baby Identification

The new Presco baby identification system consists of a soft pliable plastic bracelet or anklet which is easily and quickly locked onto the infant in the delivery room. Full information, mother's name and initials, address, date of birth, name of physician and other details can be included in the bracelet which is provided in blue and pink for quick identification of sex.

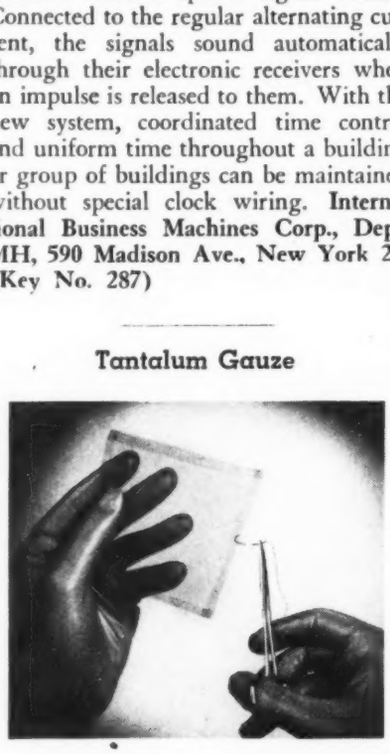
The system is contained in a plastic kit which carries complete bracelet-anklets, 1 pair of chromed surgical scissors and 2 pencils for writing information on the card which fits firmly within the unit. The bracelet is permanently locked on and will not come off until it is removed by cutting. It does not have to fit tightly and thus is not irritating, stays in place, is water tight and can be cleaned with water or alcohol. The bracelet is attractive as well as practical as it is locked on the wrist or ankle with tiny rosebuds of the identifying color. **The Presco Co., Dept. MH, 6225 Brookside Blvd., Kansas City 2, Mo. (Key No. 286)**

Electric Time System

The new electric time system developed by IBM regulates all clocks in a time system without special supervisory or clock wiring. The master clock is plugged into an ordinary light socket and electronically checks all clocks in the system individually and automatically once an hour for uniformity with the master clock. Through electronic tube action in a transmitter, the control clock sends a supervisory impulse out over the regular electric current lines and if any clock in the system is slower or faster than the master time control. it corrects itself once each hour automatically.

Automatic signaling through the program unit of the master control is also possible without special signal wiring. Connected to the regular alternating current, the signals sound automatically through their electronic receivers when an impulse is released to them. With the new system, coordinated time control and uniform time throughout a building or group of buildings can be maintained without special clock wiring. **International Business Machines Corp., Dept. MH, 590 Madison Ave., New York 22. (Key No. 287)**

Tantalum Gauze



Tantalum, a rare bluish gray metal, is essentially biologically inert and has a high degree of tissue acceptability so that in soft or on bony tissues the cellular response causes firm adhesion of the tissues to the tantalum. Ethicon Tantalum Gauze is a woven wire cloth made from fine tantalum wire in a 50 by 50 mesh and was developed principally for application in the repair of hernias involving tissue deficiencies. It has also been used in some types of nerve and eye surgery. **Ethicon Suture Laboratories, Dept. MH, New Brunswick, N. J. (Key No. 288)**

Johnson's Floor Cleaner

Developed to remove badly soiled self-polishing wax and dirt from the surface of waxed floors, Johnson's Floor Cleaner penetrates and loosens old wax and dirt when reduced with 20 parts of water. One gallon of the new cleaner is sufficient for cleaning approximately 20,000 square feet of floor.

The cleaner is a blend of soaps and detergents which penetrates quickly when diluted in hot water and applied to the surface with a mop, cloth or sprinkling can. It has been used successfully on all types of floors, including asphalt tile, rubber tile, linoleum, wood and terrazzo. **S. C. Johnson & Son, Inc., Dept. MH, Racine, Wis. (Key No. 289)**

Miniature Fluorescent Lamps

Two types of miniature fluorescent lamps have recently been announced to provide a cool light source of high intensity and uniform field, one for direct attachment to most types of microscopes and the other with supporting bracket or for attachment to a work bench.

The microscope lamp has twin 4 watt fluorescent lamps which straddle the microscope objective lenses and direct a flood of light to all surfaces of the subject under study. The design produces a light intensity of 450 foot-candles at a 3 inch working distance and the operating temperature of the lamp allows comfortable use. The other miniature lamp produces a light intensity of 550 foot-candles at a 3 inch working distance. **Stocker & Yale, Dept. MH, Marblehead, Mass. (Key No. 290)**

Vaponefrin Aerosol Mask

The new Vaponefrin Aerosol Mask has been developed to assure a favorable therapeutic response during application of aerosols in bronchopulmonary conditions. The results of months of scientific research, the new mask assures aerosol mists in optimum quantities without disturbing the patient's usual breathing pattern. It may be used alone in the administration of antibiotic aerosols or in combination with bronchodilators.

The mask consists of a Styrene plastic oronasal facepiece which is flexible and easily molded to fit oronasal contours. and a special plastic nebulizer with an outlet cap to prevent loss of medication. The motor unit is designed to deliver the therapeutically optimum amount of air for effective aerosolization and is equipped with pressure and suction unit

outlets. It is simple and convenient and eliminates the need for nursing assistance. **Vaponefrin Company, Dept. MH, 328 S. Jefferson St., Chicago 6. (Key No. 291)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 236

Cylinder Truck

The new O.E.M. Safe-Guard is a 4 wheel cylinder truck designed for transporting oxygen cylinders, for use as a portable bedside holder and as a storage unit. Completely retractable wheels and a spring locking device assure safety at whatever angle the truck may be adjusted. It is mounted on two 8 inch semi-pneumatic tires and two 3 inch ball bearing casters for noiseless, easy mobility. The truck is all welded steel construction with a beveled platform to facilitate loading and unloading and with scientifically devised leverage and balance. **Oxygen Equipment Mfg. Corp., Dept. MH, 405 E. 62nd St., New York 21. (Key No. 292)**

Small Automatic Washer

The new Junior Automatic Washer developed by Prosperity is now available with the Prosperity Formatrol which automatically completes the sequence of operations and stops the machine when the washing cycle is finished. The control gives greater production, greater economy and quality control of every load. The large drop in the Junior Automatic Washer cylinder provides the necessary mechanical action to clean even dirtiest clothes thoroughly, and the machine is designed to provide the proper rinsing action. **The Prosperity Co., Inc., Dept. MH, Syracuse 1, N. Y. (Key No. 293)**

Adding-Figuring Machine

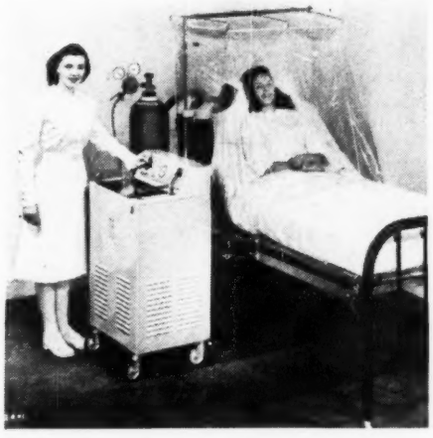
The new Underwood Sundstrand Adding-Figuring Machines have streamlined design and are finished in a new two tone gray and black combination. The machines are available with various column capacities and feature a newly designed paper tear-off knife which provides complete visibility for all figures at all times. The machine is equipped

with direct subtraction, credit balance and three point control whereby three motorized keys perform six functions: adding, subtracting, non-adding, subtotaling, totaling and printing of credit balance as either a sub-total or total. **Underwood Corp., Dept. MH, 1 Park Ave., New York 16. (Key No. 294)**

Visionaire Canopy

The improved Visionaire canopy is of strong, durable transparent material with added elasticity. It is the result of research and testing to develop the most efficient transparent canopy. Elastic tabs have been added to prevent tearing of the canopy where it fastens to the canopy support rods and the new Visionaire is available for all types, sizes and makes of apparatus. Specially designed canopies can be supplied on receipt of specifications.

The Visionaire is designed to give full view of the patient at all times and to relieve the patient of any feeling of claustrophobia. Conversation between patient and personnel or visitors can be



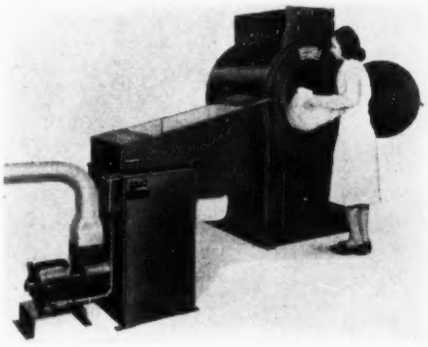
carried on without disturbing the canopy or interrupting therapy. The canopy has handy openings for care and feeding. Because of the durability of the material, the Visionaire can be sterilized and cut up for other uses after it has been discarded as a canopy. **Continental Hospital Service, Dept. MH, 18636 Detroit Ave., Cleveland 7, Ohio. (Key No. 295)**

Plastic Rubber Paint

A plastic rubber paint known as Nu-Fab has been developed for painting fabrics, wood, metal and other materials. It is available in attractive, cheerful colors and is designed for use in renewing old fabrics such as mattress covers, upholstery and draperies, as well as renewing wood and steel furniture and equipment. When applied the product becomes waterproof and fire repellent. Nu-Fab covers from 275 to 350 square feet of material per gallon. **Adhesive Products Corp., Dept. MH, 1660 Boone Ave., New York 60. (Key No. 296)**

Feather Reconditioning Unit

Pillow feathers can be quickly and effectively cleaned and fluffiness and



curl restored with the new Zone-Air feather reconditioning unit. Broken quills and heavy dirt are screened out in the Preparator from which air suction draws feathers into a processing bag. Screened feathers in seven processing bags are then placed in the Zone-Air tumbler where they are steam cleaned, dusted, dried and the natural curl and fluffiness restored. Feathers are returned to their laundered ticking by means of the Preparator.

Using the separate Preparator to transfer feathers permits cleaning feathers from 7 pillows in an 8 minute cycle. When there are no feathers to recondition, the unit can be used in drying laundry work. **The American Laundry Machinery Co., Dept. MH, Cincinnati 12, Ohio.** (Key No. 297)

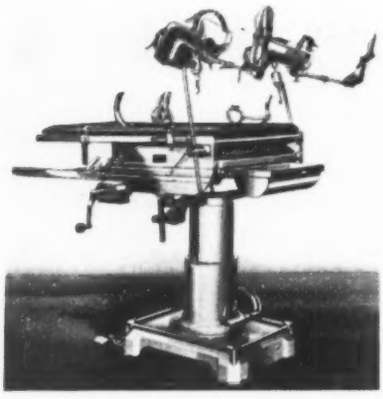
Photomicrographic Equipment

The new Model L photomicrographic camera and accessories were developed by Bausch and Lomb to meet the need for universal, medium sized equipment. It is designed to meet the specific needs of all those requiring this type of equipment and the new L Camera is described as a compact photomicrographic department in one unit. The camera is 5 by 7 inches with adapters available for smaller negative sizes. Plain and reflex camera backs are available, both taking a double holder. The front board is movable for fine focusing and the bellows draw is measured by an attached steel tape. The camera can be used either vertically or horizontally.

The supporting cabinet provides storage drawers for the accessories and the linoleum top gives a desirable working surface. The new unit with its accessories permits the use of the full range of magnifications with transmitted, phase contrast, bright field, dark field or polarized light and surface illumination. The equipment is designed to handle any photomicrographic problem quickly and efficiently. **Bausch & Lomb Optical Co., Dept. MH, Rochester 2, N.Y. (Key No. 298)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 236

Delivery and Obstetrical Table



Model A2148J Ohio-Scanlan delivery and obstetrical operating table has recently been introduced. Improvements and refinements in the new model include: leg section that is easily moved horizontally under the body section of the table top, combining compactness and simplicity of a 1 piece delivery table with the advantages of a 2 piece table and permitting its use as a labor bed as well as a delivery and operating table; Monel metal drain pan for draining of fluids, which slides back under leg section of table; anatomically designed aluminum knee crutch and soleplate assembly which accommodates variations in size and contour and is based on the principle of positioning the patient from the hips, thus providing maximum flexibility for tall or short patients; a sturdy mobile base which ensures positive stability, and four concealed casters so arranged as to elevate table and base when mobility is desired. **The Ohio Chemical & Mfg. Co., Dept. MH, 1400 E. Washington St., Madison 10, Wis. (Key No. 299)**

Skin Finish Gloves

The new Pioneer Skin-Finish Rollpruf surgical gloves are made of latex rubber in a new texture that is exceptionally sheer without loss of strength, toughness or durability. Known as Skin-Finish, the fingers of the new gloves are said to grip wet slippery surfaces as if dry, and to provide increased finger-tip sensitivity. The new gloves have the flat-banded Rollpruf cuffs and are designed to fit snugly, without wrinkles. They are processed to stand repeated sterilizing. **The Pioneer Rubber Co., Dept. MH, Willard, Ohio. (Key No. 300)**

Rauh Surface Pyrometer

Minute differences in temperatures between adjacent skin areas may be read immediately through the use of the Rauh Surface Pyrometer. This new diagnostic aid in determining circulatory conditions and their response is a highly sensitive instrument with a mechanism which assures a high degree of accuracy. It is only necessary to set the instrument to the value indicated on the mercurial thermometer before taking a series of skin temperature readings. Scales are calibrated for both Centigrade and Fahrenheit within the range of 60 to 110 degrees F. The Pyrometer is portable, with two small dry cells to supply illumination, and is housed in a mahogany case approximately 8 inches square. **John Bunn Corp., Dept. MH, 1 Vernon Place, Buffalo 14, N. Y. (Key No. 301)**

Patients' Gowns

The complete new line of patients' gowns announced by Melrose includes three styles which conform to standards established by the U. S. Department of Commerce for patients' gowns. The

standards were set up by the Department in conjunction with a committee consisting of manufacturers, distributors and hospitals. Gowns conforming to the standard carry a special label.

Observance of the standards in the new styles protects hospitals and minimizes the possibility of purchasing unsatisfactory merchandise. The new line represents slight changes in dimensions which bring it into full conformity with the standards. **Melrose Hospital Uniform Co., Inc., Dept. MH, 115 University Place, New York 3. (Key No. 302)**

Bottled Water Cooler

The new Temprite bottled water cooler is designed for cup service where bottled spring water is used. The metal cabinet is attractively finished in baked-on enamel and the cooler has a capacity for cooling 3 gallons per hour to 50 degree drinking water temperature in 90 degree room temperature. It is obtainable with either hermetic or open-type condensing units and the cooler and storage tank are of stainless steel. **Temprite Products Corp., Dept. MH, 47 Piquette Ave., Detroit 2, Mich. (Key No. 303)**

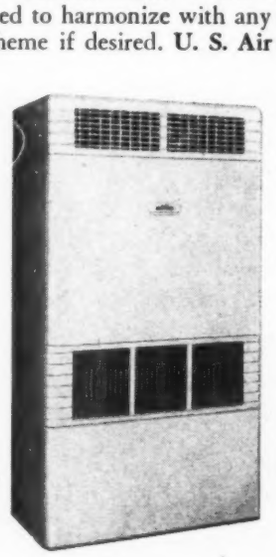
Air Diffuser

A recent addition to the Kno-Draft line of adjustable air diffusers is a new unit intended for use where air is to be both discharged from and returned or exhausted through a common unit. The supply air is discharged from between the outer and intermediate cones and the return or exhaust air is drawn through the center section of the diffuser. Supply air volume is controlled by a damper, operated by peripheral screws. The inner assembly is raised or lowered to vary the air direction and the movement is controlled by air direction adjustment screws. The center cone return air damper rotates on a central operating screw. **W. B. Connor Engineering Corp., Dept. MH, 114 E. 32nd St., New York 16. (Key No. 304)**

Packaged Air Conditioning Unit

The redesigned packaged air conditioning unit recently announced by U. S. Air Conditioning Company cools, dehumidifies, filters, circulates and ventilates. Features of the new model include a newly designed hermetically-sealed motor-compressor unit which is completely sealed against leaks, dirt and moisture; glass fiber insulation which makes the unit vermin and ratproof; inexpensive, disposable type air filters, and more compactness. The unit is available in 3 and 5 ton capacities and is readily installed by simple connections to an electric outlet, a water system and a drain.

The unit can be used for air conditioning operating rooms, wards or other areas and a remote installation may be made, the conditioned air being distributed through a duct system. The attractive, welded steel cabinet has smooth exterior finish which may be repainted to harmonize with any decorative scheme if desired. **U. S. Air Conditioning Co., Dept. MH, Minneapolis 14, Minn. (Key No. 305)**



Address manufacturers for further information and prices—or use Readers' Service blank on page 236

Muscle Stimulator

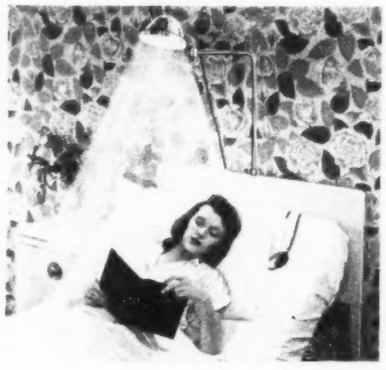
A variable frequency wave generator has been developed which can stimulate paralyzed muscles with electric current and thus prevent them from wasting away through disuse. Jointly developed by engineers of the General Electric Company and the General Electric X-Ray Corporation, the instrument applies electric current which alternately contracts and relaxes paralyzed muscles 24 times per minute, thus giving the muscles the benefit of prolonged exercise without effort on the part of the patient. The current frequency may be varied over a wide range so that the desirable frequency can be obtained for each patient, depending upon duration of illness, age and extent of paralysis. **General Electric X-Ray Corp., Dept. MH, 4855 W. McGeoch Ave., Milwaukee 14, Wis. (Key No. 306)**

Power Meat Cutter

The new Biro power meat cutter is built of stainless steel for ease of cleaning, attractive appearance and sanitation. The smooth, hard finish does not corrode or rust and leaves no place for refuse to accumulate. The new machine is the same size as the regular Biro Model 22 which has cutting clearance 12½ inches high and 11 inches wide and has a total table area of 28 by 28⅞ inches with an overall height of 61 5/16 inches. It is especially designed for institutional use. **Biro Mfg. Co., Dept. MH, Marblehead, Ohio. (Key No. 307)**

Telescopic Bed Light

The Peters Jr. Model "T" telescopic bed light has been developed in cooperation with hospital bed manufacturers and is built into the head of steel paneled beds. The beds are designed with the receptacle to hold the telescopic arm which fits into the headboard and thus makes the light an integral part of the



bed unit. It does not interfere with nursing or other service as it can be easily pushed to one side. The light head can also be taken from the arm for hand use for examinations and other purposes. The friction telescopic action retains the light at any height or position desired without knobs or screws.

The telescopic swing arm is of formed steel tubing, spring sustained, the reflector is of heavy gauge spun steel designed for maximum efficiency, the lamp handle is heat resistant, and all metal parts are plated over a heavy copper protecting base. Standard finishes are satin chromium and gold bronze. **Luminous Equipment Co., Dept. MH, 900 W. Van Buren St., Chicago 7. (Key No. 308)**

Tip-Proof Foot Stool

The new Hospac foot stool is so designed as to be tip-proof, no matter where the patient may rest his weight on it in getting in or out of bed. The 10 by 14 inch platform is covered with

slip-proof ribbed rubber and edged with aluminum-linoleum molding. The chrome plated tubular steel legs are reenforced with tubular struts for added strength and are arched and spread to prevent the stool from tipping. The stool is 8 inches high, has rubber tipped feet and is a sanitary, attractive and safe footstool for use wherever needed in the hospital. **Hospital Accessories Co., Dept. MH, 792 Nostrand Ave., Brooklyn 16, N. Y. (Key No. 309)**

Slimline Germicidal Lamp

General Electric has developed a 36 inch slimline type germicidal lamp capable of operating at four different germ-killing intensities. It is designed for use in conventional fixtures for upper air protection, in ventilating systems to kill germs in circulating air and for protection of foods and other supplies in store rooms. Its smaller size and high ultraviolet output reduce cost while giving effective protection. **General Electric Co., Dept. MH, Nela Park, Cleveland 12, Ohio. (Key No. 310)**

Posture Cot

An ambulance cot which is adjustable to Fowler, knee lift, chaise longue or

level position has been introduced as the Posture Cot. In addition to its multi-posture adjustability, the cot is full size, yet weighs only 35 pounds. Welded tubular aluminum construction is used on the chassis except for the cot fastener posts which are of stainless steel. All chassis joints are smooth-welded with no exposed bolts and the cot is designed for heaviest loads. It is rattleproof, empty or loaded, under all road conditions.

The Posture Cot has a full 30 inch back rest which is held in any desired position by a rigid lock. The back rest also serves as a carrying hand rail either in level or elevated adjustment, permitting level carry on stairs. The cot has full retracting, self-locking arm rests which operate without interfering with mattress or bedding and which may be used for carrying. Other features include: long side lift rails; no projecting parts; long wheelbase to ensure against tipping; caster wheels inset under the cot, and a rubber faced all metal foot rest which is adjustable to any position and is removable. It is manufactured by E. L. Schofield Inc. and distributed by **Superior Coach Corp., Dept. MH, Lima, Ohio. (Key No. 311)**

Children's Circus Gowns

Brightness and cheer are available for the pediatric department through the new Whitehouse children's circus gowns recently announced. The idea was originated by an eminent child psychologist and the gowns, with their prints of nursery characters, are full of interest for children. Several different designs are available and the gowns are shipped assorted to provide variety for the patients.

Printed on twill jean with vat dyes, the gowns are made in raglan sleeve pattern with all points of strain especially reenforced. They are designed for long wear and to withstand hard laundering. The gowns are available in small, medium and large sizes and yard goods in the same gay patterns can also be obtained for making draperies and bedspreads. **Whitehouse Mfg. Co., Dept. MH, 325 N. Michigan Ave., Chicago 1. (Key No. 312)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 236

Kidde Insufflator

The new Kidde Utero-tubal Insufflator, a device for delivering carbon dioxide in controlled amounts and at controlled pressures into the uterine tubes for diagnostic or therapeutic purposes, has been accepted by the Council on Physical Medicine of the American Medical Association. A weighted piston, called a gasometer, has been injected into the CO_2 line as a safety feature which prevents the possibility of introducing a pressure surge into the patient. It is simple to operate and is supplied with either the direct recording Kymograph or Mercurial Manometer pressure recorder.

The Kidde Opaque Oil Attachment, a valveless oil attachment to hold opaque medium for roentgenologic work, may be had as an accessory. With this attachment the opaque medium is delivered to the patient under the automatic and positive pressure control of the gasometer. **Kidde Mfg. Co., Inc., Dept. MH, Bloomfield, N. J. (Key No. 313)**

Cap and Drain Tube

The new Davol urinal bottle cap and connecting drain tube designed to fit snugly on standard, one-gallon glass bottles, has been developed to provide a handy, convenient, time saving, sanitary cap and tube for drainage bottles. The drain tube is attached by a glass connector to catheter or indwelling tube and the cap is so fitted that there is little likelihood of spilling should the bottle be tipped. **Davol Rubber Co., Dept. MH, Providence 2, R. I. (Key No. 314)**

Portable Repair Shop

Maintenance can be more easily and quickly handled with the "Handy-Matic," a motorized, completely equipped portable repair shop. An original type of flexible shaft machine mounted on a compact, easily transported cabinet, containing 25 accessory tools and 2 dozen supplies, the unit provides the necessary tools for any maintenance job.

The cabinet, 32 inches high, is of all steel construction with gray crackle finish and glossy black trim. It is equipped with shelves in which the tools and accessories for sanding metal or wood, drilling, wire brushing, grinding, buffing, sawing, waxing, paint or varnish removal and other work are readily available and all are interchangeable. The "Handy-Matic" rides on three caster legs and can be quickly transported to the place of need. **Wyzenbeek & Staff, Inc., Dept. MH, 832 W. Hubbard St., Chicago 22. (Key No. 315)**

Pharmaceuticals

Bacitracin

Bacitracin, a new antibiotic for local application, which is not yet given parenterally for systemic use, has proved effective for injection by local infiltration into the base of pyogenic lesions, for irrigation of infected wounds and for application in ointment form for the treatment of infectious conditions of the skin and of external ocular infections. Research has shown it to have a profound antibacterial action against many gram-positive pathogens and to be destructive for certain gram-negative organisms.

The new product is offered as Bacitracin powder in sterile vials, Bacitracin ointment for surgical and dermatologic use and Bacitracin ophthalmic ointment by **C.S.C. Pharmaceuticals, Div. of Commercial Solvents Corp., 17 E. 42nd St., New York 17. (Key No. 316)**

Pentaquine Phosphate

Pentaquine Phosphate is an antimalarial intended primarily for use in combination with quinine as a curative agent for vivax malaria. The product closely resembles pamaquine in its action for white-skinned adults but the therapeutic dose has proved less toxic than pamaquine. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 317)**

Eticylol

The Ciba brand of ethinyl estradiol, the most potent form of estrogen for oral administration, is now known as Eticylol. This prescription form of the female sex hormone is convenient and pleasant to take with no after-taste and is supplied in 0.02 and 0.05 mg. in bottles of 100 and 250. It is indicated in the treatment of female hypogonadism, menopausal syndrome, functional uterine bleeding and other conditions. **Ciba Pharmaceutical Products, Inc., Dept. MH, Summit, N. J. (Key No. 318)**

Lozilles

Lozilles are new antibiotic-analgesic throat lozenges providing 2 mg. of tyrothricin and 2 mg. of propesin in a pleasantly flavored lozenge form. Developed for local antibiotic treatment of mouth and throat infections, a single Lozille, when allowed to dissolve slowly in the mouth, produces an effective topical concentration of tyrothricin for as long as one half hour and Propesin, the surface anesthetic, affords prompt relief of pain and discomfort without noticeably affecting the taste sense. **White Laboratories, Inc., Dept. MH, 113 N. 13th St., Newark 7, N.J. (Key No. 319)**

Litexin

Litexin is a liquid liver and iron product with a pleasant taste for the treatment of secondary anemias and as a general systemic tonic. It was developed for children and for adults who object to unpalatable preparations. **Eli Lilly & Co., Dept. MH, Indianapolis 6, Ind. (Key No. 320)**

Triple Immunizing Agent

Parke, Davis has developed a Diphtheria-Tetanus-Pertussis (Sauer) Alum Precipitated combination for use in a simplified schedule to reduce the number of injections to confer immunity against the three diseases. The antigenic substances are concentrated to a small fluid volume to reduce the size as well as the number of injections necessary for immunization. **Parke, Davis & Co., Dept. MH, Detroit 32, Mich. (Key No. 321)**

Streptomycin Ointment

A new Streptomycin Ointment containing 5,000 micrograms of streptomycin per gram, suspended in a water-soluble greaseless type ointment base, has been announced for treatment of infections containing both gram-positive and gram-negative organisms. It is available in 1 ounce tubes. **Bristol Laboratories, Inc., Dept. MH, Syracuse 1, N.Y. (Key No. 322)**

Procaine Penicillin G

Procaine Penicillin G in Oil for intramuscular injection has been added to the Winthrop-Stearns line. Designed for prolonged effect and less painful injection, each 1 cc. contains 300,000 units of penicillin in free-flowing suspension with 2 per cent of the new dispersing agent, aluminum monostearate. It is supplied in a multiple dosage package of 10 cc. in 1 cc. cartridges with a disposable plastic syringe. **Winthrop-Stearns Inc., Dept. MH, 170 Varick St., New York 13. (Key No. 323)**

Arthralgen

Arthralgen is a new arthralgesic unguent for the local treatment of rheumatic and allied disorders. The product was developed to provide rapid relief from painful symptoms and combines a potent vasodilator in a washable base. The unique ointment base permits rapid penetration of the skin for quick vasodilator and analgesic action. **Whittier Laboratories, Division Nutrition Research Laboratories, Dept. MH, 4210 W. Peterson Ave., Chicago 30. (Key No. 324)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 236

Presidon 'Roche'

Presidon 'Roche' is a new sedative-hypnotic, not a barbiturate, which has a mild, prompt and relatively short action. Clinical reports indicate that the product is free from habit-forming tendencies and is rapidly broken down and eliminated by the body. It is supplied in 0.2 Gm. tablets, scored for convenient adjustment of doses, in vials of 20 and 100 tablets. **Hoffmann-La Roche Inc., Dept. MH, Nutley 10, N.J. (Key No. 325)**

Sterile Petrolatum

White Petrolatum U.S.P. — Sterile. Baybank brand is a dependably sterile product which still retains all the desirable properties of white petrolatum. It is intended for topical application to burns and wounds, in packs, drains, protective coverings or as a lubricant. It is supplied in 1 ounce collapsible tubes which may be immersed in a suitable bacterial solution before use in the operating room. **Baybank Pharmaceuticals, Inc., Division of Chesebrough Mfg. Co., Cons'd, Dept. MH, 17 State St., New York 4. (Key No. 326)**

P-A-D Tablets

P-A-D Tablets combine the analgesic properties of phenacetin and acetylsalicylic acid with the sympathomimetic action of desoxy-ephedrine. They are designed for relieving headache and the symptoms of the acute common cold, also to alleviate painful smooth muscle cramps. The tablets are supplied in packages of 100 and 500. **The Upjohn Company, Dept. MH, Kalamazoo 99, Mich. (Key No. 327)**

Tertiasul

Tertiasul, as its name implies, contains the three sulfas, sulfadiazine, sulfamerazine and sulfathiazole, in equal proportions in tablet form for broad bacteriostatic effectiveness. It is supplied in bottles of 100 and 1000 tablets. **William H. Rorer, Inc., Dept. MH, 901 Drexel Bldg., Philadelphia 6, Pa. (Key No. 328)**

Delvinal-Diethylstilbestrol

Delvinal-Diethylstilbestrol was developed for the treatment of the menopausal state where a need for both sedation and estrogen replacement therapy is indicated. The tablets combine the sedative properties of sodium vinbabital with the estrogenic activity of stilbestrol. The product is supplied in bottles of 100 and 1000 tablets. **Sharp & Dohme, Inc., Dept. MH, Philadelphia 1, Pa. (Key No. 329)**

Product Literature

• **A complete service of cost estimates as well as decorative selections** is available for those planning a new hospital or nurses' home or rehabilitation of existing buildings. In conjunction with the new **Fabron catalog,** recently published, containing an assortment of 166 attractive patterns of this washable fabric wall covering, Frederic Blank & Co., Inc., 230 Park Ave., New York 17, offers a decorative service for administrators and architects. On request, a folder is prepared by the company in which every interior of the building is designated by number, and quantities of wall and ceiling covering required are listed. A decorative selection is suggested, based on the size of the room, its light exposure, its function and the colors which may already be in the room. Each selection is indicated on the floorplan or blueprint with cost figured for each room, walls and ceilings separately. Samples of suggested coverings are attached to the estimate, each marked for the suggested location. The estimate is a complete record of the Fabron requirements covering patients' rooms, corridors, lobbies, offices, public rooms and other areas when the building is handled as a unit or of any section of the building which is designated. The estimate also serves as a record for future reference. **(Key No. 330)**

• **Catalog No. 48** issued by Snowhite Garment Mfg. Co., 2880 N. 30th St., Milwaukee 10, Wis., is a most attractively printed booklet with cellophane binding illustrating the various styles in tailored uniforms and operating room apparel manufactured by the company. They are presented with descriptive information and three pages are devoted to caps, collars and cuffs, monograms, name tapes and buttons and pins. The inside front cover gives information on tailoring details which will interest the buyer. **(Key No. 331)**

• The Marble Institute of America, 108 Forster Ave., Mt. Vernon, N. Y., has prepared a handbook on marble, **"Standard Specifications and Scaled Detail Plates of Interior Marble."** It contains complete information for specifying interior and exterior marble, describes marble classifications, finishes and uses and recommends setting materials and procedures. Names and addresses of Institute members are included in the book. **(Key No. 332)**

• Information on the new **Magnesium Folding Chairs** developed by Louis Rastetter and Sons Co., Fort Wayne 1, Ind., is given in a folder issued by that company. Simplicity of folding, flat stacking qualities, light weight and attractive appearance are some of the points covered. **(Key No. 333)**

• A motion picture which illustrates hazards in hospitals and stresses accident prevention has been made by the Saint Paul-Mercury Indemnity Company, 111 W. Fifth St., St. Paul 2, Minn. Entitled **"Diagnosis; Danger,"** the film is educational for executives and personnel of hospitals and may be secured without charge for group showings. The 16 mm. film received an award as the best non-theatrical film in the Occupational Safety Field. **(Key No. 334)**

• **"Public Relations in Fund-Raising for Hospitals"** is the title of a booklet published by Howard T. Beaver and Associates, Fund-Raising Consultants, 612 N. Michigan Ave., Chicago 11. The material contained in the booklet was presented as an address by Mr. Beaver at a recent hospital conference and opens with the statement that public relations is not more and better publicity but starts with the fundamental principle on which the hospital operates. **(Key No. 335)**

• **"The Newest Thing From the Land of the Sun!"** is the intriguing title of an attractive folder issued by the Florida Citrus Commission, Lakeland, Fla. The folder tells the story of concentrated Florida orange juice, concentrated by a revolutionary method which results in a juice with delicious natural flavor and no loss of vitamins and minerals. The canned concentrate is available in either frozen or liquid form and is easily prepared by merely adding water. **(Key No. 336)**

• The Fifth Edition of the very practical and helpful booklet, **"Washroom Advisory Service,"** is now available from Scott Paper Company, Chester, Pa. Utilizing the experience and knowledge gained from a study of over 300,000 washrooms in all types of buildings, Scott Washroom Advisory Service has prepared this booklet to help solve some of the problems encountered and to suggest efficient layout for washrooms of all types. Convenience, safety, economy and efficiency are stressed in the booklet which contains 35 line drawings suggesting effective plans for washrooms of almost all sizes. The booklet should prove particularly useful to those planning new buildings or remodeling of old ones. **(Key No. 337)**

• A 24 page catalog showing the line of **"Soda Fountains and Luncheonette Equipment"** developed by the company is available from the Liquid Carbonic Corp., 3100 S. Kedzie Ave., Chicago 23. Full details, illustrations and specification of all standard units are included to help the administrator in planning new fountain installations. **(Key No. 338)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 236

• **"Steps to Beautiful Floors"** is the title of an attractively laid out and printed brochure illustrating the colors and some of the suggested combinations of Fremont Rubber Tile. Information on the product, its comfort, ease of cleaning, wear resistance and other qualities, is included in the folder issued by Fremont Rubber Co., 105 McPherson Highway, Fremont, Ohio. **(Key No. 339)**

• The new **"Seco-Superex Custom-Bilt Soda Fountains"** catalog SS-1 issued by Seco Company Inc., 5206 S. 38th St., St. Louis 16, Mo., should be of real value and assistance to any administrator planning to install a fountain or lunch room in his institution. Full information on the new Superex "Custom-Bilt" Soda Fountain is given, together with suggested sketches for fountain installations, information on special features of the Superex, illustrations showing actual installations, descriptive information and illustrations of each separate fountain section, with sketches showing suggested arrangements, data on sandwich and hot food unit equipment and other details needed in planning an installation. **(Key No. 340)**

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it.

Bessie Covert,
Editor, "What's New for Hospitals"

- ☐ 279 Laminex Hypodermic Needle
- ☐ 280 Plastic Covering Material
- ☐ 281 Developer Hanger
- ☐ 282 AM-7 Dishwashing Machine
- ☐ 283 Aerosol Penicillin Pump
- ☐ 284 Overbed Table
- ☐ 285 Applegate Mark-It
- ☐ 286 Baby Identification
- ☐ 287 Electric Time System
- ☐ 288 Tantalum Gauze
- ☐ 289 Johnson's Floor Cleaner
- ☐ 290 Miniature Fluorescent Lamps
- ☐ 291 Vaponefrin Aerosol Mask
- ☐ 292 Safe-Guard Cylinder Truck
- ☐ 293 Small Automatic Washer
- ☐ 294 Sundstrand Adding-Figuring Machine
- ☐ 295 Visionaire Canopy
- ☐ 296 Plastic Rubber Paint
- ☐ 297 Feather Reconditioning Unit
- ☐ 298 Photomicrographic Camera
- ☐ 299 Delivery and Obstetrical Table
- ☐ 300 Skin Finish Gloves
- ☐ 301 Rauh Surface Pyrometer
- ☐ 302 Patients' Gowns
- ☐ 303 Bottled Water Cooler
- ☐ 304 Air Diffuser
- ☐ 305 Packaged Air Conditioning Unit
- ☐ 306 Muscle Stimulator
- ☐ 307 Biro Power Meat Cutter
- ☐ 308 Telescopic Bed Light
- ☐ 309 Tip-Proof Foot Stool
- ☐ 310 Slimline Germicidal Lamp
- ☐ 311 Posture Cot
- ☐ 312 Children's Circus Gowns
- ☐ 313 Kidde Insufflator
- ☐ 314 Rubber Cap and Drain Tube
- ☐ 315 Portable Repair Shop
- ☐ 316 Bacitracin
- ☐ 317 Pentaquine Phosphate
- ☐ 318 Eticylol
- ☐ 319 Lozilles
- ☐ 320 Litexin
- ☐ 321 Triple Immunizing Agent
- ☐ 322 Streptomycin Ointment
- ☐ 323 Procaine Penicillin G
- ☐ 324 Arthralgen
- ☐ 325 Presidon 'Roche'
- ☐ 326 Sterile Petrolatum
- ☐ 327 P-A-D Tablets
- ☐ 328 Tertiasul
- ☐ 329 Delvinal-Diethylstilbestrol
- ☐ 330 Fabron Catalog and Decorative Service
- ☐ 331 Catalog No. 48
- ☐ 332 Handbook
- ☐ 333 Magnesium Folding Chairs
- ☐ 334 "Diagnosis; Danger"
- ☐ 335 "Public Relations in Fund-Raising"
- ☐ 336 "The Newest Thing From the Land of the Sun"
- ☐ 337 "Washroom Advisory Service"
- ☐ 338 Catalog
- ☐ 339 "Steps to Beautiful Floors"
- ☐ 340 Catalog SS-1
- ☐ 341 "Apple Dishes"
- ☐ 342 Books
- ☐ 343 Books

I should also like to have information on the following products

NAME _____ TITLE _____

HOSPITAL _____

STREET _____

CITY _____ STATE _____

MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc
919 N. Michigan Ave., Chicago 11, Ill.

An attractive booklet offering **"Apple Dishes by Eight Master Chefs"** has been issued by Appalachian Apple Service, Inc., Martinsburg, West Virginia. The booklet has been prepared for use by institutions and in addition to general information on apples, it contains quantity recipes for many apple dishes, illustrated in full colors. **(Key No. 341)**

Book Announcements

W. B. Saunders Company, W. Washington Square, Philadelphia 5, Pa. DeGowin, Hardin and Alsever, "Blood Transfusions," 580 pp. **(Key No. 342)**

The Williams & Wilkins Co., Mt. Royal & Guilford Aves., Baltimore 2, Md. Feldman, "Clinical Roentgenology of the Digestive Tract," 3rd ed., 897 pp., $8. **(Key No. 343)**

Suppliers' Plant News

Cutter Laboratories, Berkeley 1, Calif., manufacturer of pharmaceuticals and biologicals, announces the appointment of **Donn R. Court,** formerly general salesmanager, in charge of sales and distribution for the company, the position formerly held by G. "Pres" Snow who resigned as of November 1. **(Key No. 344)**

G. "Pres" Snow, formerly in charge of sales and distribution for Cutter Laboratories, has become affiliated with **Hyland Laboratories, 4534 Sunset Blvd., Los Angeles 27, Calif.,** as President of the company. **(Key No. 345)**

Dixie Cup Company, Easton, Pa., manufacturer of paper cups and containers, announces removal of its Los Angeles office and warehouse to larger quarters at 2600 E. 12th St. **(Key No. 346)**

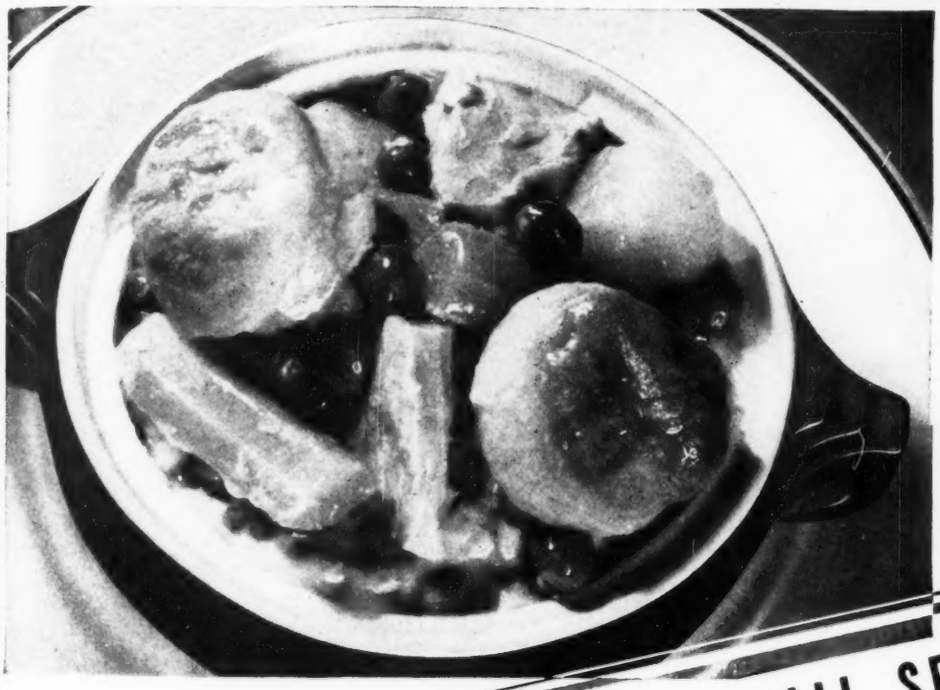
Fedders-Quigan Corp., manufacturer of air conditioners and refrigeration parts, announces removal of its headquarters from 57 Tonawanda St. to **1280 Niagara St., Buffalo 13, N. Y. (Key No. 347)**

Green Spot, Inc., manufacturer of fruit-flavored beverages, announces removal from 658 Mesquite St. to **1501 Beverly Blvd., Los Angeles 26, Calif. (Key No. 348)**

Norwich Pharmacal Company, Norwich, N.Y., announces opening of a new 5 story and basement administration building, the first unit in a building program designed to provide more space for the company's manufacturing activities. **(Key No. 349)**

Vacuum Foods Corp., processor of citrus juices, announces change of address from 561 Fifth Ave. to **445 Park Ave., New York 22. (Key No. 350)**

Printed in U.S.A.



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